

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1868 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01844

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont--- rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Own Home		e. STREET ADDRESS RD 1	
3. NAME OF DECEASED (Type or print) Howard Jonathan Anders		4. DATE OF DEATH February 9 19 61	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 21, 1885
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY P.E. Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John P. Anders		14. MOTHER'S MAIDEN NAME Mary Elizabeth Fraley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-18-0839	
17. INFORMANT James H. Anders		Address Thurmont, Md. RD 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B.O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) B.O. Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 2-11-61	22c. NAME OF CEMETERY OR CREMATORY Lewistown Cemetery	22d. LOCATION (City, town, or county) (State) Lewistown Fred. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Clevager		ADDRESS Thurmont, Maryland	
24a. REC'D BY REGISTRAR DATE FEB 14 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as soon as possible. The word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS
COUNTY OF DALLAS

Page 1

MEDICAL CERTIFICATION

VR A15 (4)
ISM 9/59

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For the purpose of the survey of the
land owned by the State of Texas
and for the purpose of the survey of the
land owned by the State of Texas

Survey of the
land owned by the State of Texas

1900

1900

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01846

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Market</u>		c. LENGTH OF STAY IN lb <u>18 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>State Route 144</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Oliver Burns Baker</u>		4. DATE OF DEATH Month Day Year <u>February 22 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 26, 1886</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Charles Vernon Baker</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth A. Norwood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-18-3966</u>	
17. INFORMANT <u>Mrs. Oliver B. Baker - New Market</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.00</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>Few minutes</u> <u>3 years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec.</u> , 19 <u>60</u> , to <u>Jan.</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Jan.</u> , 19 <u>61</u> , and that death occurred at <u>6:30</u> A. M. from the causes on and on the date stated above.			
ACTUAL SIGNATURE <u>W.B. Culwell</u> M.D.		ADDRESS (Street, city or town, state) <u>900 So. Main St. Frederick, Md.</u>	
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>		DATE SIGNED <u>Feb. 22, 1961</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB 25-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVET CEM</u>		22d. LOCATION (City, town, or county) (State) <u>FREDERICK MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lucian K. Falconer</u> ADDRESS <u>New Market, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 28 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneel</u>	

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1871

Reg. Dist. No. 1847

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Frederick <div style="text-align: right;">MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL) Frederick	c. LENGTH OF STAY IN 1b 10 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS 921 North Market Street	
3. NAME OF DECEASED (Type or print) Frederick Reese Beall Jr.		4. DATE OF DEATH Month February Day 25 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1924
9. AGE (in years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months 11 Days 11	11. IF UNDER 24 HRS. Hours 11 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator Construction Company		10b. KIND OF BUSINESS OR INDUSTRY Frederick County	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Frederick R. Beall Sr.		14. MOTHER'S MAIDEN NAME Dark Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 2 217-12-2727	
17. INFORMANT Mrs Charlotte Beall, 921 N. Market St		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fractured Skull 823 X DUE TO Crushed right chest Fractured ribs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple lacerations DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 11 hours			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto ran over head on into the automatic traffic control signal pole	
20c. TIME OF INJURY Month, Day, Year 12-19-60 2/25/61		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 355 & 850	
20e. (City or town) Mr. Frederick Frederick, Md		20f. (County) Frederick	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B.O. Thomas		DATE SIGNED 2/25/61	
EXAMINER'S NAME (Type) B.O. Thomas, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-28-61	
22c. NAME OF CEMETERY OR CREMATORY Rocky Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Frederick County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dwyer		24a. REC'D BY REGISTRAR FEB 28 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Knecht			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your office. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1871

RECEIVED IN DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, cause of death, and signature.

NAME: _____

AGE: _____ SEX: _____

CAUSE OF DEATH: _____

SIGNATURE: _____

1872

CERTIFICATE OF DEATH

Reg. Dist. No.

01848

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN lb 50 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 207 North Delaware Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Eliza Last Bennett		4. DATE OF DEATH Month 2 Day 18 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-13-1887
9. AGE (In years last birthday) yrs. 83		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel W. George		14. MOTHER'S MAIDEN NAME Virginia Yakey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Informant Address Mrs. Elizabeth Flagg, Brunswick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 434-1 DUE TO acute congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/16 , 19 61 , to 2/18 , 19 61 , that I last saw the deceased alive on 2/18 , 19 61 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. B. Carpenter		ADDRESS (Street, city or town, state) Brunswick, Md. DATE SIGNED 2/20/61	
PHYSICIAN'S NAME (Type) W. B. CARPENTER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-21-1961	22c. NAME OF CEMETERY OR CREMATORY Saint Marks	22d. LOCATION (City, town, or county) (State) Petersville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE G. P. Fuld		ADDRESS Brunswick, Maryland	
24a. REC'D BY REGISTRAR FEB 23 '61		24b. REGISTRAR'S SIGNATURE W. H. J. Kears	

1. The purpose of this report is to provide a summary of the results of the study conducted during the period from January 1, 1964, to December 31, 1964. The study was conducted in accordance with the plan of work approved by the Board of Directors on January 15, 1964.

2. The study was conducted in accordance with the plan of work approved by the Board of Directors on January 15, 1964. The study was conducted in accordance with the plan of work approved by the Board of Directors on January 15, 1964.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 7, MARYLAND

CERTIFICATE OF DEATH

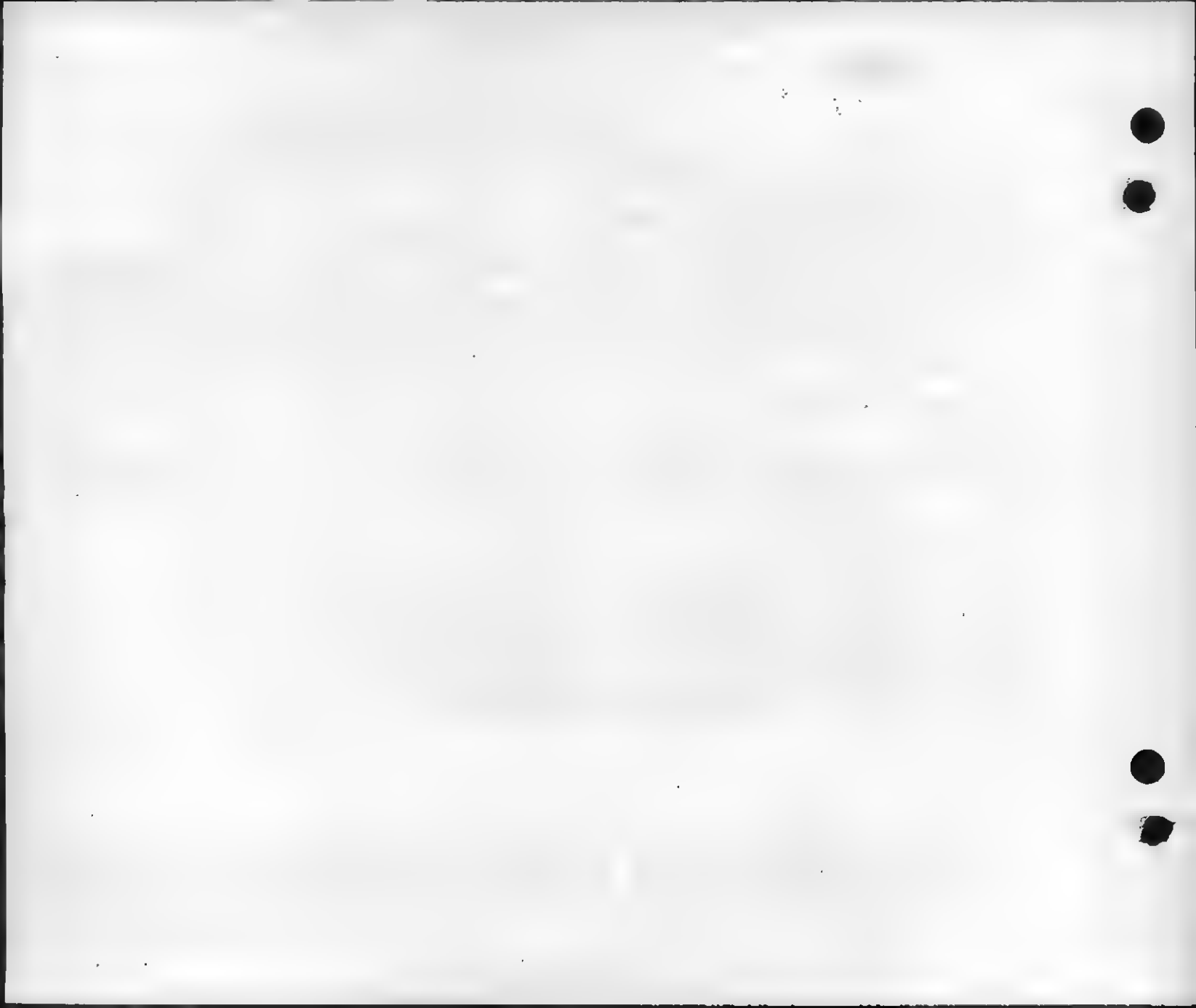
1873

Form 9 Film 0283 3/20/61

118417

1 PLACE OF DEATH a. COUNTY Frederick MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen		c. LENGTH OF STAY IN 1b 575+ days	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital		d. STREET ADDRESS Clarksburg	
3 NAME OF DECEASED (Type or print) First Minnie Middle --- Last Bennett		4. DATE OF DEATH Month 2 Day 27 Year 1961	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 30, 1883
9. AGE (In years lost birthday) 76 7/7 yrs		IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Georg P. Craft		14. MOTHER'S MAIDEN NAME Elle Roberts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO. None	
17 INFORMANT Record of Victor Cullen Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis - 002 DUE TO (b) 002X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/28 1961 to 2/27 1961 , that (I) (we) last saw the deceased alive on 2/27 1961 , and that death occurred on 2/27 1961 at 10 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Michael G. Zavis		22b. DATE SIGNED 2/27/61	
22c. PHYSICIAN'S NAME (Type) Michael G. Zavis, M.D., Supt		22d. ADDRESS Cullen, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/3/61	
23c. NAME OF CEMETERY OR CREMATORY Methodist		23d. LOCATION (City, town, or county) (State) Clarksburg, MD	
24. FUNERAL DIRECTOR'S SIGNATURE M. L. Cragg		25a. REC'D BY REGISTRAR DATE MAR 3 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kneass			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in for the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1874

01850

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> <u>County</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Walkersville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick County Chronic Hosp.</u>		d. STREET ADDRESS <u>Frederick Co. R.F.D # 7</u>	
3. NAME OF DECEASED (Type or print) <u>Simon</u> <u>Peter Biddinger</u>		4. DATE OF DEATH <u>Feb.</u> <u>16</u> <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3 1888</u>
9. AGE (In years last birthday) <u>72</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Servant</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mr. John Biddinger</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. Ida Eaves</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs. Helen Hahn</u>		Address <u>Chronic Hospital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>192X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiovascular disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar</u> <u>1960</u> to <u>Feb 15</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>Feb 15</u> <u>1961</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>H. F. Kline</u>		22b. DATE SIGNED <u>Feb 17 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. F. KLINE</u>		22d. ADDRESS <u>Frederick Md.</u>	
23a. BURIAL, CREMAT ON, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/18/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Chapel</u>		23d. LOCATION (City, town, or county) (State) <u>Libertytown, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>S. C. Barton</u>		25a. REC'D BY REGISTRAR <u>FEB 21 '61</u> DATE	
ADDRESS <u>Walkersville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



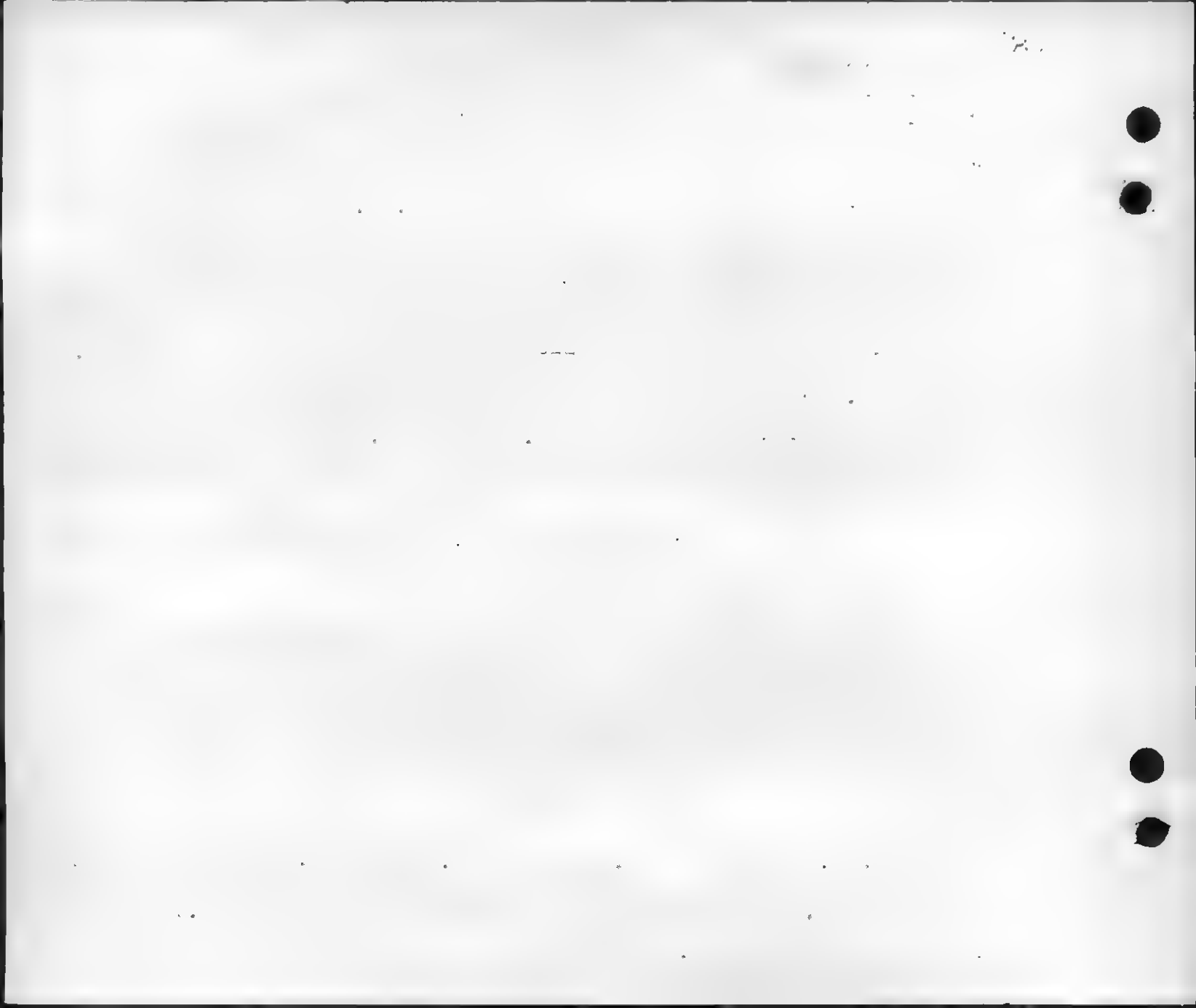
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1875

01851

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Woodbine</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				d. STREET ADDRESS <u>R. D. 2</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Valeria Gay BRIGHTWELL</u>				4. DATE OF DEATH Month Day Year <u>Feb 18 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 15 1961</u>	
9. AGE (In years last birthday) yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>William C. Brightwell</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn Barnes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT Address <u>Mr. William C. Brightwell, Same as # 2</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 172x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Embryonal tumor over lower spine</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above							
22a. SIGNATURE <u>W. B. Culwell</u> M. D.				22b. DATE SIGNED <u>2/18/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>W. B. Culwell M. D.</u>				22d. ADDRESS <u>Mt. Airy, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 20, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Linganore Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Frederick Co., Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>C. M. Waltz, Winfield, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 21 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Carlton S. Knaus</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

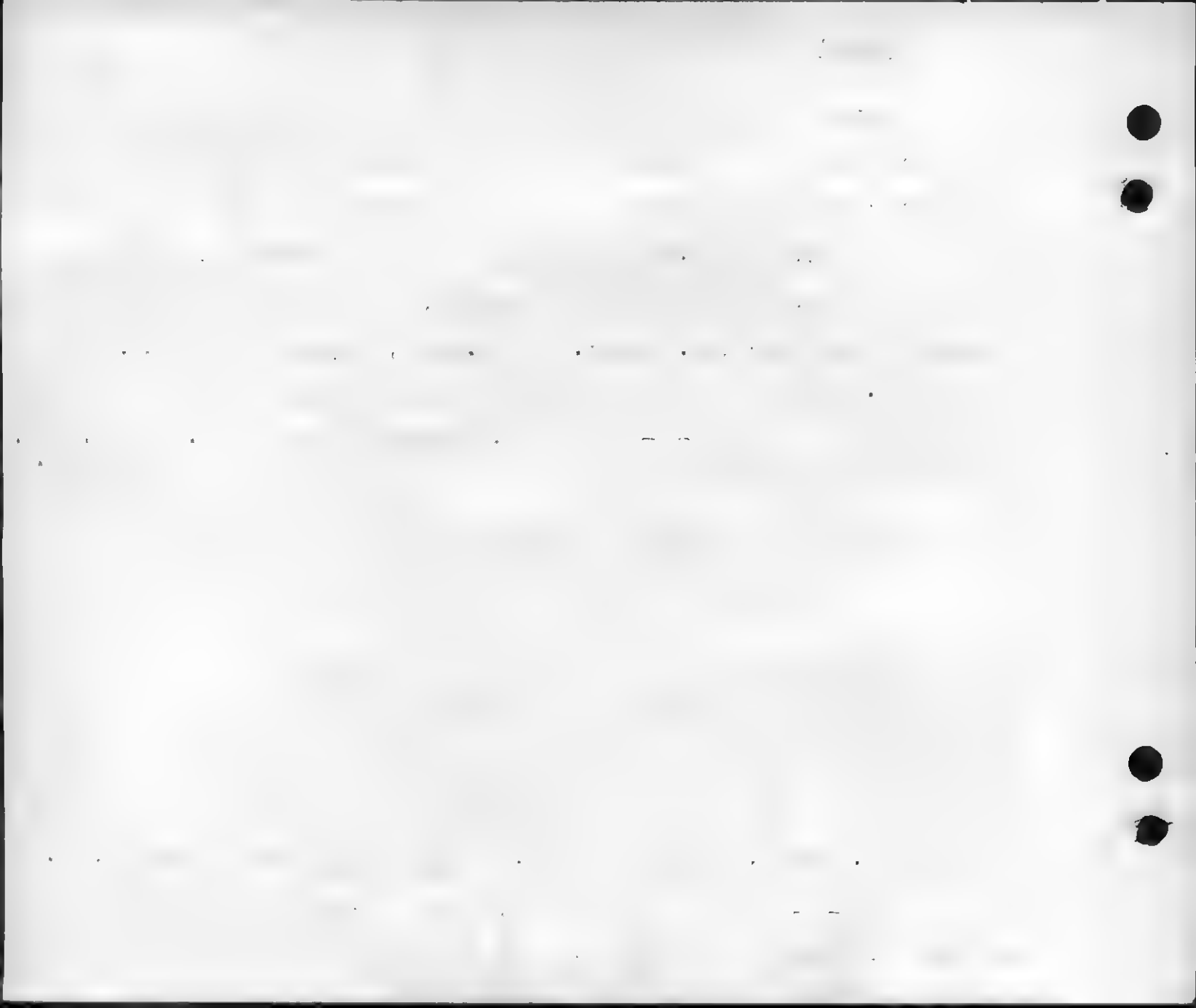
VR A15 (4)
15M 9/59

1876

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01852

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
f. STREET ADDRESS 101 West 12th Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Clayton Howard Cronise		4. DATE OF DEATH Month Day Year February 15, 1961 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 22, 1875
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Pattern Maker		10b. KIND OF BUSINESS OR INDUSTRY Fred. Iron Co.	
11. BIRTHPLACE (State or foreign country) Wheatland, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Americus C. Cronise		14. MOTHER'S MAIDEN NAME Alice Brean	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-10-3253	
17. INFORMANT Miss A. Katherine Cronise		Address 101 W. 12th St. Fred.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 44 6X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic nephrosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Months years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour -a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/1 , 19 54 to 2/15 , 19 61 , that (I) (we) last saw the deceased alive on 2/15 , 19 61 , and that death occurred at 11:00 AM , from the causes and on the date stated above			
22a. SIGNATURE James B. Thomas		22b. DATE SIGNED 2-15-1961	
22c. PHYSICIAN'S NAME (Type) Dr. James B. Thomas		22d. ADDRESS M.D., 228 North Market Street Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-18-1961	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Bailey		25a. REC'D BY REGISTRAR DATE FEB 20 1961	
ADDRESS Frederick, Maryland		25b. REGISTRAR'S SIGNATURE John S. Kenna	

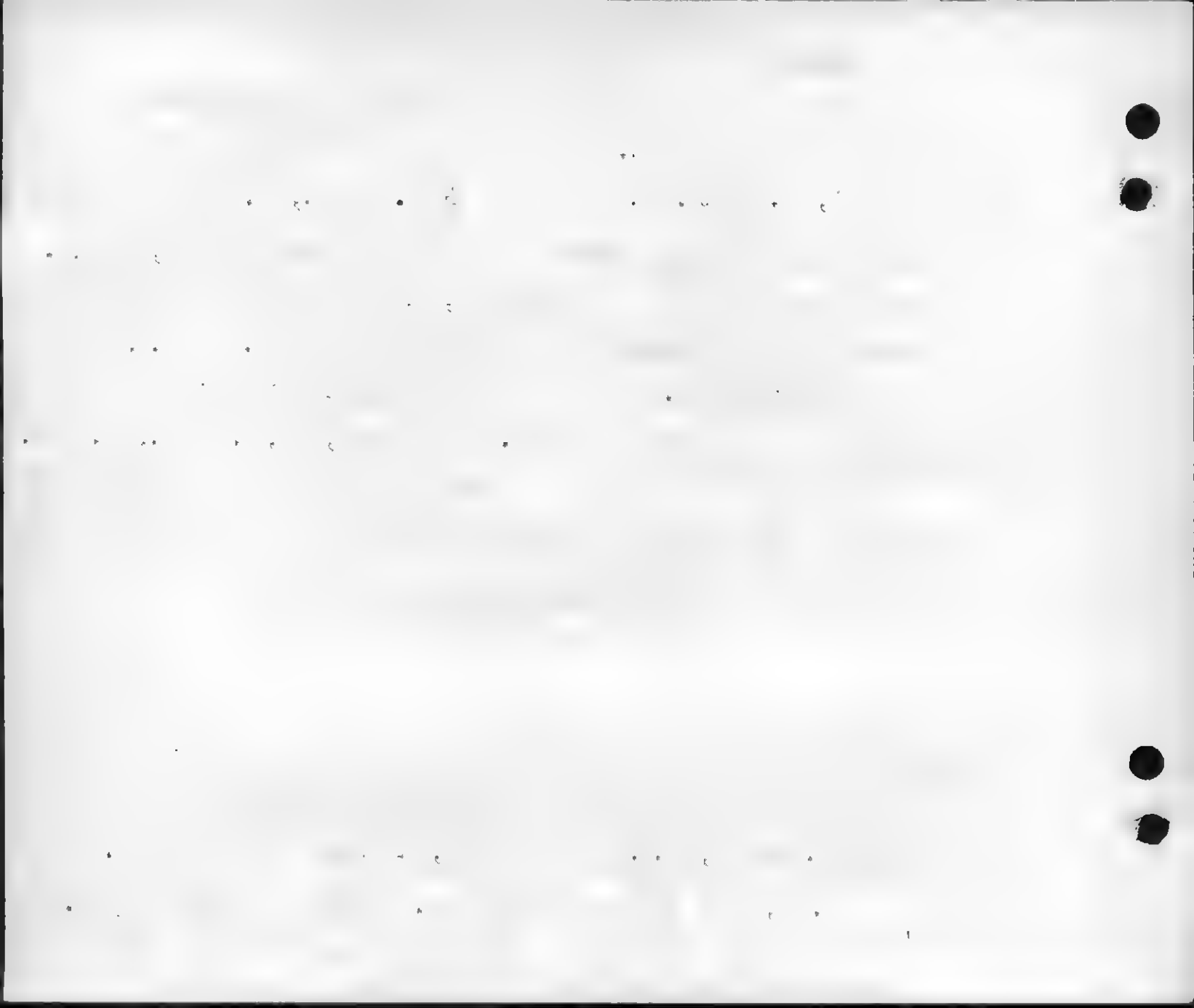


TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by a funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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1877
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
01853

1. PLACE OF DEATH a. COUNTY FREDERICK b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK c. LENGTH OF STAY IN lb 8 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 24, W. 12 th. St.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK d. STREET ADDRESS 24 W. 12 th., St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALICE ELIZABETH HIMES DARNER First Middle Last 4. DATE OF DEATH February 17, 1961 Month Day Year		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH July 6, 1874 9. AGE (In years lost birthday) 86 yrs IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Homemaker 11. BIRTHPLACE (State or foreign country) Frederick County Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME John Henry Himes. 14. MOTHER'S MAIDEN NAME Sarah Catherine Stine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO None 17. INFORMANT Miss. Daisy Danner, 24, W. 12 th., St. Fred. Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 42.0.0 DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 months years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from Nov 1959 to Feb 17, 1961 , that (I) (we) last saw the deceased alive on Feb 2, 1961 , and that death occurred at 4 AM , from the causes and on the date stated above 22a. SIGNATURE Rex R. Martin, M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) REX R. MARTIN, M.D. 22d. ADDRESS 220, N. Market FREDERICK, Md. 22b. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF Feb. 20, 1961 23c. NAME OF CEMETERY OR CREMATORY Jefferson Reformed Cem. 23d. LOCATION (City, town, or county) (State) Jefferson, Frederick, Md.		24. FUNERAL DIRECTOR'S SIGNATURE DALLER'S FUNERAL HOME ADDRESS FREDERICK, Maryland 25a. REC'D BY REGISTRAR DATE FEB 20 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hines	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1878

01854

1. PLACE OF DEATH a. COUNTY Frederick				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown				c. LENGTH OF STAY IN 1b 29 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Herbert Middle F. Last Davis				4. DATE OF DEATH Month 2 Day 12 Year 1961			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/1/1890		9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months 71 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) high school principal, public school				10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jefferson Davis				14. MOTHER'S MAIDEN NAME Martha Stewart			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W.W.1				16. SOCIAL SECURITY NO. 212-38-7615		17. INFORMANT Mrs. Evelyn Davis, Middletown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic Heart disease 420.1 DUE TO Ch. Valvular Heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerosis DUE TO (c) Arterio sclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary occlusion (2) attacks							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1960 to Feb. 12, 1961 , that (I) (we) last saw the deceased alive on Feb. 12, 1961 , and that death occurred at 4:45 PM , from the causes and on the date stated above.							
22a. SIGNATURE J. Elmer Harp				22b. DATE SIGNED 2-13-61		22c. PHYSICIAN'S NAME (Type) Dr. J. Elmer Harp	
22d. ADDRESS Middletown, Md.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 2/15/1961		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		23d. LOCATION (City, town, or county) (State) Shippensburg, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE gladhill Company, Middletown, Md.				25a. REC'D BY REGISTRAR FEB 15 '61		25b. REGISTRAR'S SIGNATURE Arthur E. Kline	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from this as a file burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1879

01855

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b Since 1-26-61			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLAYTON Middle OSCAR Last DEGRANGE				4. DATE OF DEATH Month February Day 13 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 13 Nov 1874	
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farm Tenant		11. BIRTHPLACE (State or foreign country) Middletown, Md.	
13. FATHER'S NAME David DeGrange				14. MOTHER'S MAIDEN NAME Josephine (Last name unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-28-0952		17. INFORMANT Address Lloyd S. DeGrange, Jefferson, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 33 <input checked="" type="checkbox"/> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) Senility						INTERVAL BETWEEN ONSET AND DEATH 19 Days 10 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/25, 1961 to 2/13, 1961 , that (I) (we) last saw the deceased alive on 2/13, 1961 , and that death occurred at 8:40P M, from the causes and on the date stated above							
22a. SIGNATURE A. T. Brice				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 15 Feb 1961	
22c. PHYSICIAN'S NAME (Type) A. T. Brice, M. D.				22d. ADDRESS Jefferson, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-16-61		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		23d. LOCATION (City, town, or county) (State) Jefferson, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				25a. REC'D BY REGISTRAR FEB 17 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1880

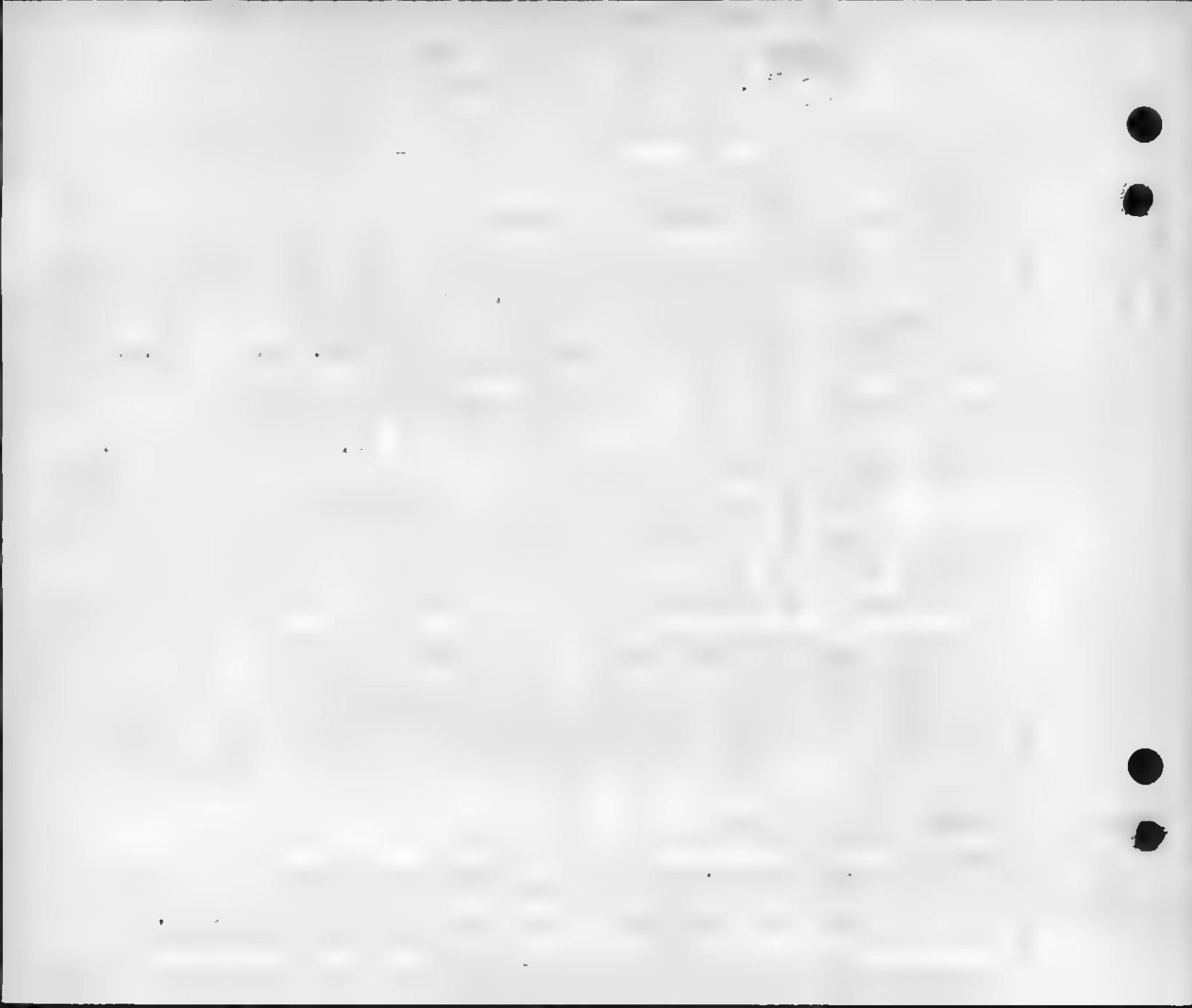
CERTIFICATE OF DEATH

Reg. Dist. No. 01856

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural - Pearl</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>		d. STREET ADDRESS <u>Route 6</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Robert</u> Last <u>Diggs</u>		4. DATE OF DEATH Month <u>February</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 18- 1903</u>
9. AGE (In years last birthday) <u>53</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer - Brick yard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>*****</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick, Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Luther Diggs</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Mae Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Pearl Diggs - Rt. 6 Frederick, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> DUE TO <u>Arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I attended the deceased from <u>March 1, 1948</u> , to <u>Feb. 15, 1961</u> , that I last saw the deceased alive on <u>Feb. 15, 1961</u> , and that death occurred at <u>5:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B.O. Thomas Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Frederick Md</u> DATE SIGNED <u>2/16/61</u>	
PHYSICIAN'S NAME (Type) <u>B.O. Thomas Jr.</u>		Professional Building - Frederick, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-18-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Nope Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.E. Hicks III</u>		ADDRESS <u>Frederick, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 20 1961</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in in the funeral director's page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



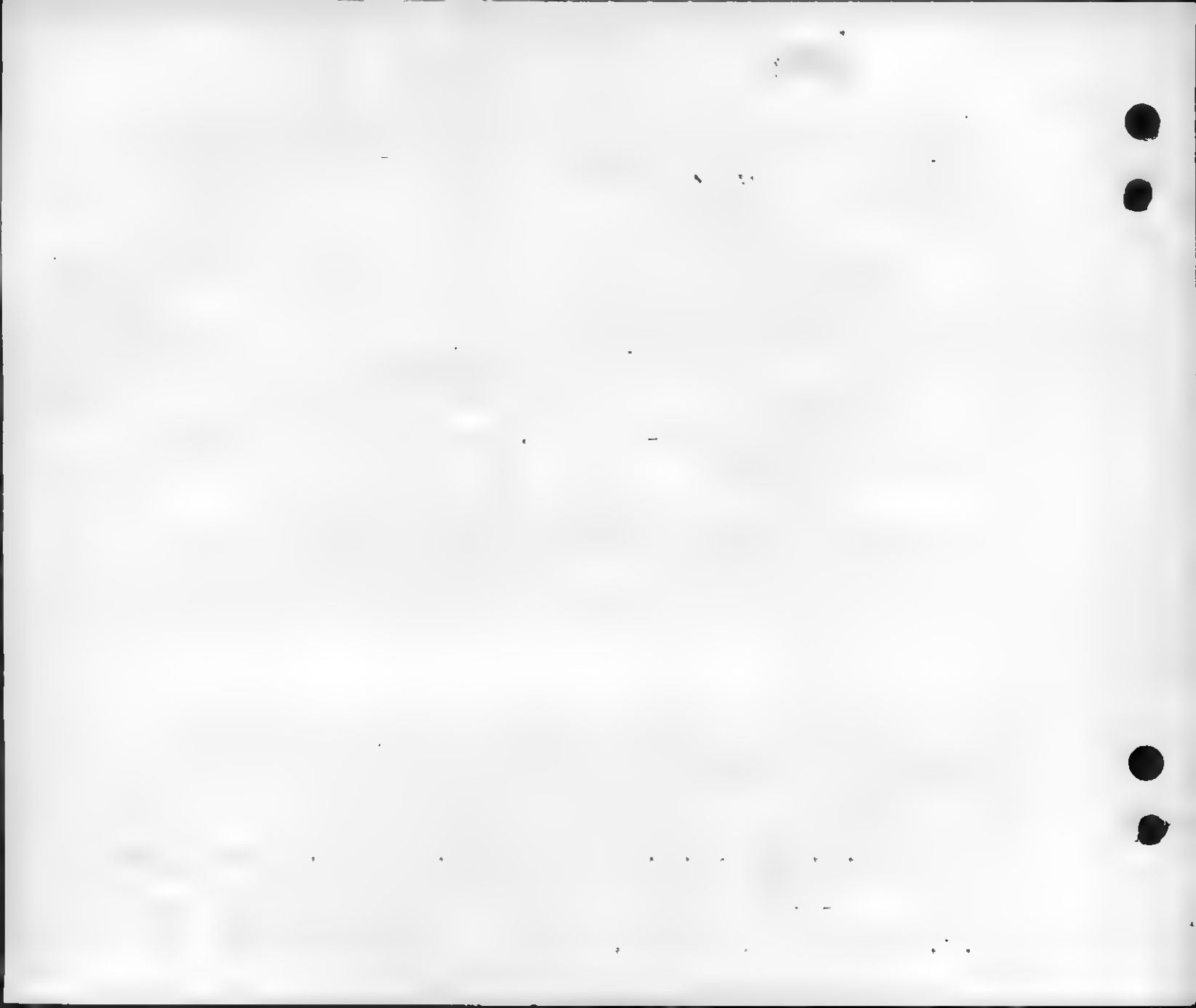
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1881

01857

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Since 2-19-61			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle MARKELL Last DUTROW				4. DATE OF DEATH Month February Day 22 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7 March 1899	
9. AGE (In years last birthday) 61 yrs		IF UNDER 1 YEAR Months 61 Days 0 Hours 0 Min.		IF UNDER 24 HRS Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Sourin Dutrow				14. MOTHER'S MAIDEN NAME Nettie Cramer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 219-36-4277		17. INFORMANT Address Mrs. Rose Dutrow (Same as item #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Arteriosclerotic Heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 5 yrs -							INTERVAL BETWEEN ONSET AND DEATH 10 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1960 to Feb 22, 1961 , that (I) (we) last saw the deceased alive on Feb 22, 1961 , and that death occurred at 4:15 PM , from the causes and on the date stated above.							
22a. SIGNATURE B. O. Thomas		M. D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE 23 Feb 1961			
22c. PHYSICIAN'S NAME (Type) B. O. Thomas, M. D.		22d. ADDRESS 228 N. Market St., Frederick, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-25-61		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				25a. REC'D BY REGISTRAR FEB 27 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

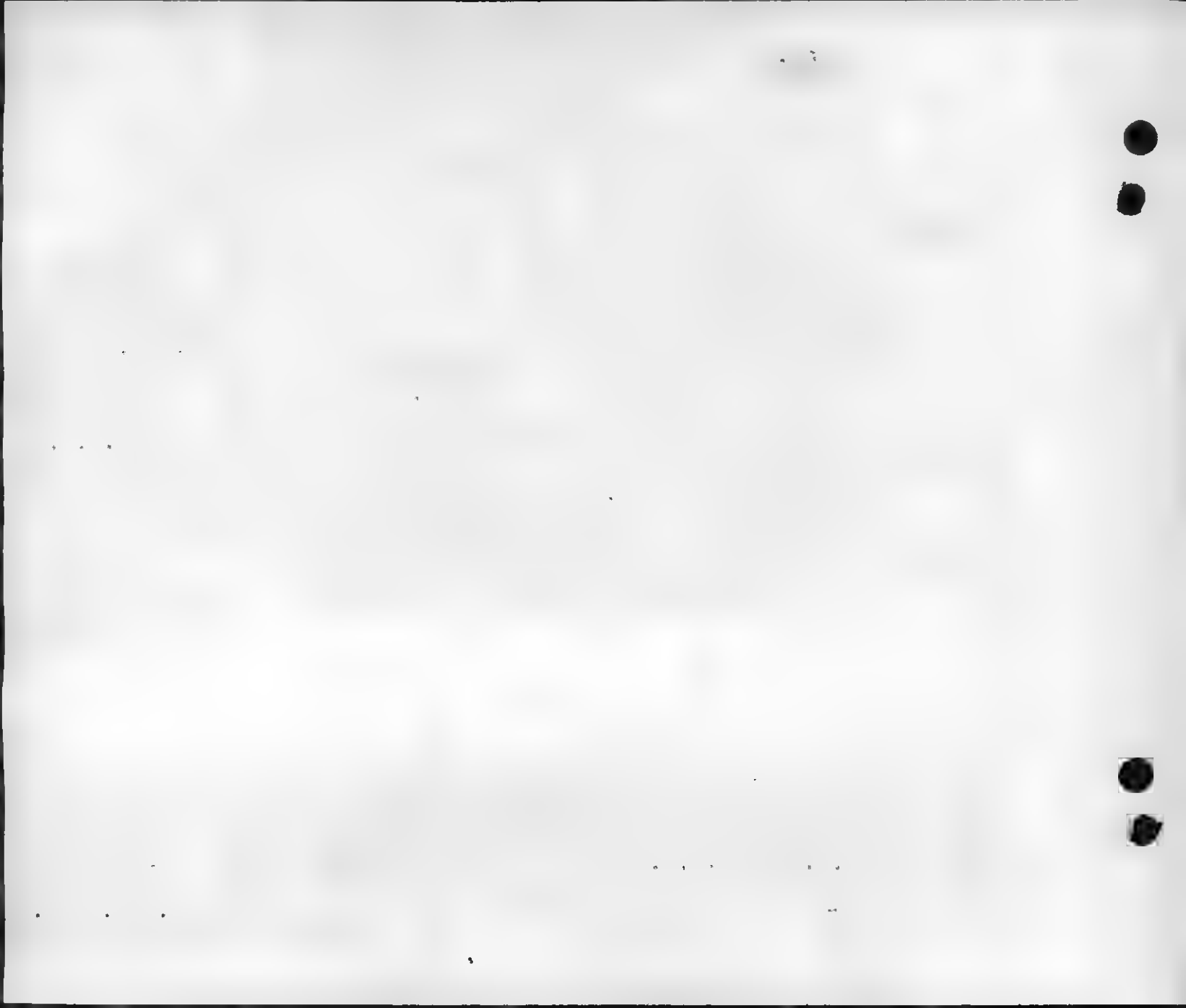
Reg. Dist. No.

01858

FOR STATE
HEALTH DEPT.

1882

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewistown c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Own Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont R.F.D.4 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Howard Franklin Eckenrode		4. DATE OF DEATH Month February Day 4 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1953
9. AGE (In years last birthday) 7 yrs.		10. IF UNDER 1 YEAR Months 7 Days 19	11. IF UNDER 24 HRS. Hours 61 Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Frederick County	
11. BIRTHPLACE (State or foreign country) Frederick County		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George A. Eckenrode		14. MOTHER'S MAIDEN NAME Emma E. Groshon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Emma E. Eckenrode, Thurmont R.F.D.4		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Obstruction and Gangrene DUE TO Small bowel Conditions, if any, which gave rise to immediate cause (b) Congenital Adhesions Band (a), stating the underlying cause lost. (c) Congestive Heart Failure PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. O. Thomas		DATE SIGNED	
EXAMINER'S NAME (Type) B. O. Thomas, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> February 6, 1961	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-9-61	22c. NAME OF CEMETERY OR CREMATORY Lewistown Cemetery	22d. LOCATION (City, town, or county) (State) Lewistown Fred. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Brager		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR FEB 8 '61		24b. REGISTRAR'S SIGNATURE Charles S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1883

CERTIFICATE OF DEATH

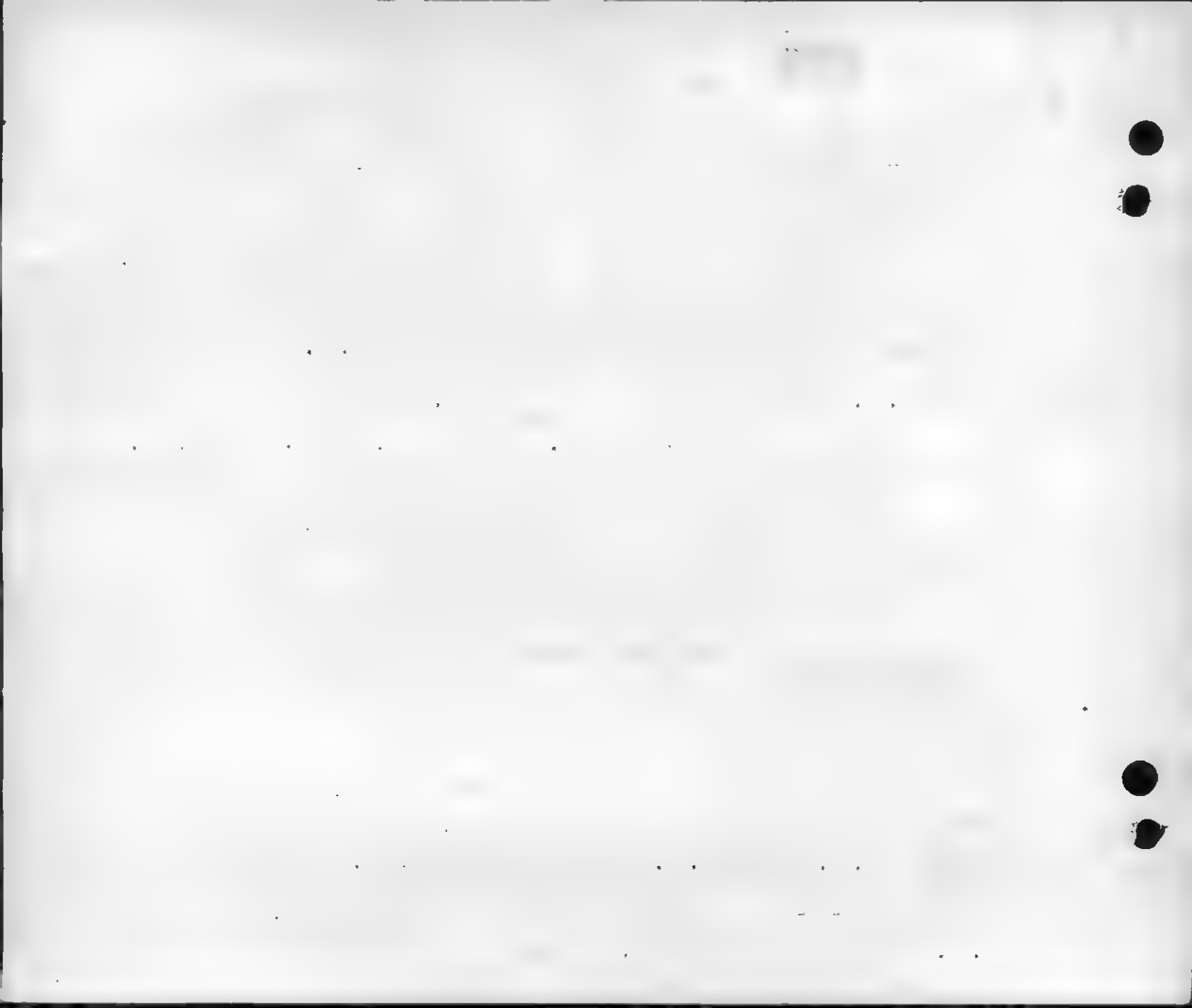
Reg. Dist. No.

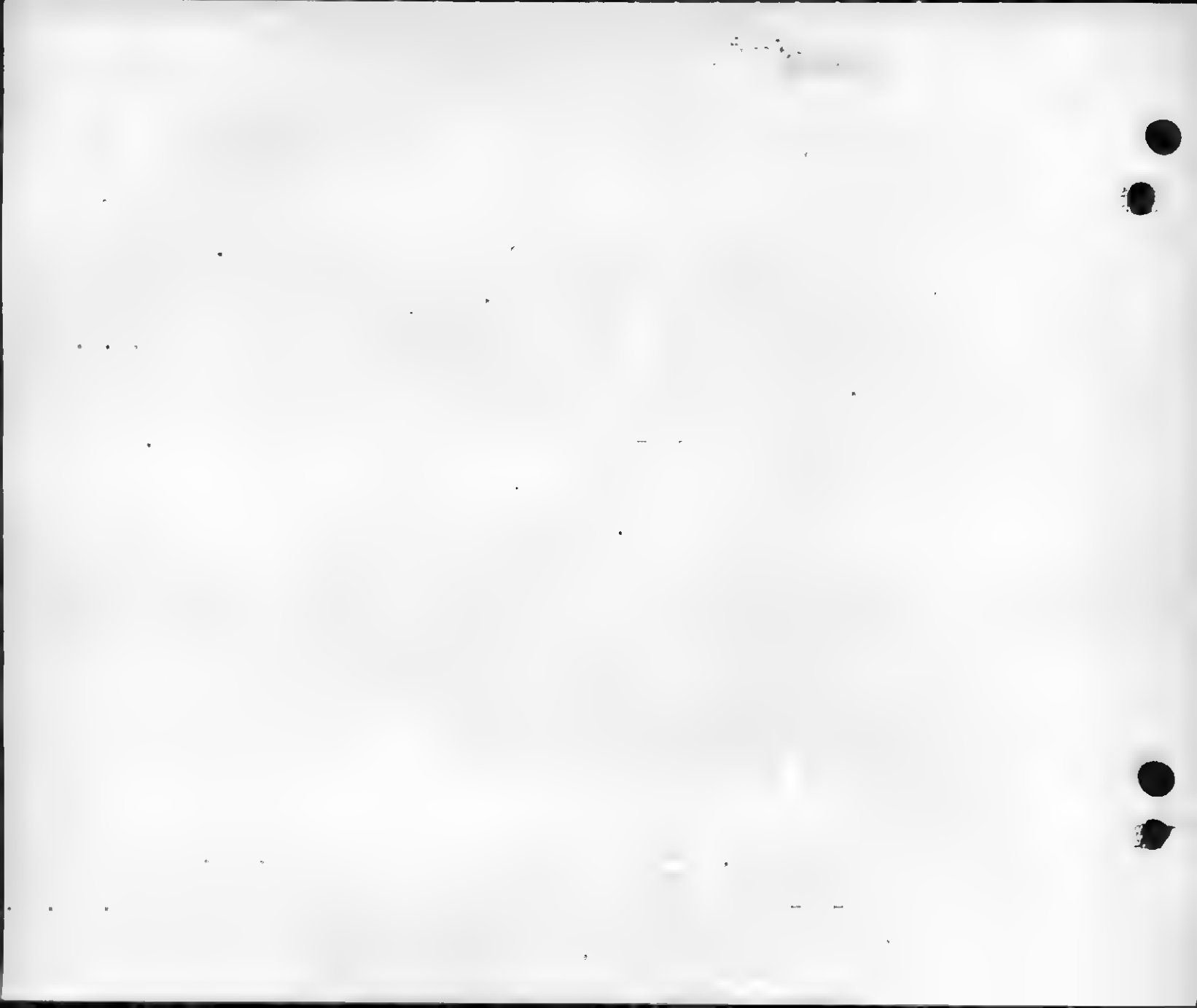
0185

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write PLURAL and give nearest town) Knoxville-Rural RD#1 c. LENGTH OF STAY IN 1b 65 Years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knoxville-Rural RD#1 d. STREET ADDRESS Near Knoxville e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUTH Middle ELLEN Last FERRELL		4. DATE OF DEATH Month February Day 19 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 Nov 1891
9. AGE (In years last birthday) yrs. 69		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George J. B. Lewis		14. MOTHER'S MAIDEN NAME Rose V. Tucker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT J. Edgar Ferrell, RD#1, Knoxville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the gall 155.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hadden a generalized mutation DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 yrs.		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB 19 1961 to 2-19-61 , that I last saw the deceased alive on 2-19-1961 , and that death occurred at 8:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Brunswick, Md. DATE SIGNED 2-19-61			
ACTUAL SIGNATURE C. E. Pruitt, M. D.		M.D. Brunswick, Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-22-61	22c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery	22d. LOCATION (City, town, or county) (State) Jefferson, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR FEB 23 1961		24b. REGISTRAR'S SIGNATURE W. E. Jones	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



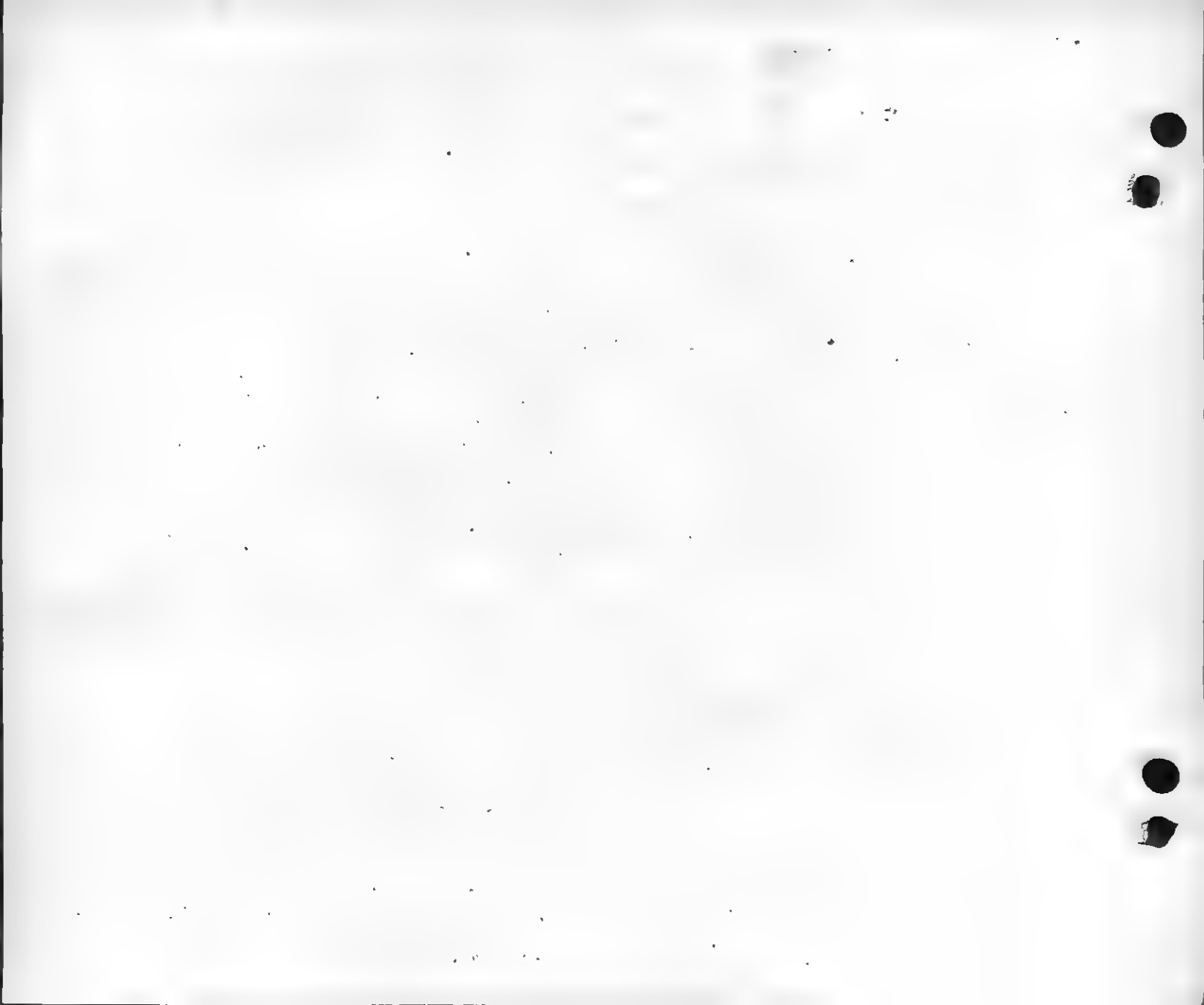


1885

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LIBERTY TOWN</u>		c. LENGTH OF STAY IN 1b <u>YEARS</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LIBERTY TOWN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM ARDENE FRITZ</u>		4. DATE OF DEATH Month Day Year <u>FEB 6 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 MAR. 1893</u>
9. AGE (in years lost birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>MATTHIAS FRITZ</u>		14. MOTHER'S MAIDEN NAME <u>JULIA ANN ZEPP</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>217-01-4088</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Senile Dementia</u> <u>450.0</u> DUE TO <u>Senile Dementia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senile Dementia</u> DUE TO (c) <u>Senile Dementia</u>		18. INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Dementia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 13, 1961</u> to <u>Feb 5, 1961</u> , that I last saw the deceased alive on <u>Feb 5, 1961</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. H. Messler M.D.</u>		DATE SIGNED <u>Feb 6, 1961</u>	
PHYSICIAN'S NAME (Type) <u>J. H. MESSLER M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8 FEB 61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FAIRMOUNT CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>LIBERTY TOWN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Adams</u>		ADDRESS <u>LIBERTY TOWN MD</u>	
24a. REC'D BY REGISTRAR <u>FEB 9 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Adams</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the following information: 1. Name of the deceased, 2. Date of death, 3. Place of death, 4. Usual residence, 5. Cause of death, 6. Date of birth, 7. Age, 8. Sex, 9. Race, 10. Marital status, 11. Birthplace, 12. Citizen of what country, 13. Father's name, 14. Mother's maiden name, 15. Was deceased ever in U. S. Armed Forces? (Yes, no, or unknown), 16. Social Security No., 17. Informant, 18. Cause of death (Enter only one cause per line for (a), (b), and (c)), 19. Was autopsy performed? (Yes, no, or unknown), 20a. Accident was underlying or contributing cause of death (If either, notify medical examiner), 20b. Describe how injury occurred (Enter nature of injury in Part I or Part II of item 18), 20c. Time of injury (Month, day, year, hour, a. m., p. m.), 20d. Injury occurred (While at work, Not while at work), 20e. Place of injury (Home, farm, factory, street, office bldg., etc.), 20f. (City or town), (County), (State), 21. I certify that (I) (this hospital) attended the deceased from Feb. 27, 1961, to Feb. 28, 1961, that (I) (we) last saw the deceased alive on Feb. 27, 1961, and that death occurred at 11:00 A. M. from the causes and on the date stated above. 22a. Signature, M.D., 22b. Date signed, 22c. Physician's name (Type), 23a. Burial, cremation, or removal (Specify), 23b. Date thereof, 23c. Name of cemetery or crematory, 23d. Location (City, town, or county), (State), 24. Funeral director's signature, address, 25a. Rec'd by registrar, date, 25b. Registrar's signature.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1886
CERTIFICATE OF DEATH

01862

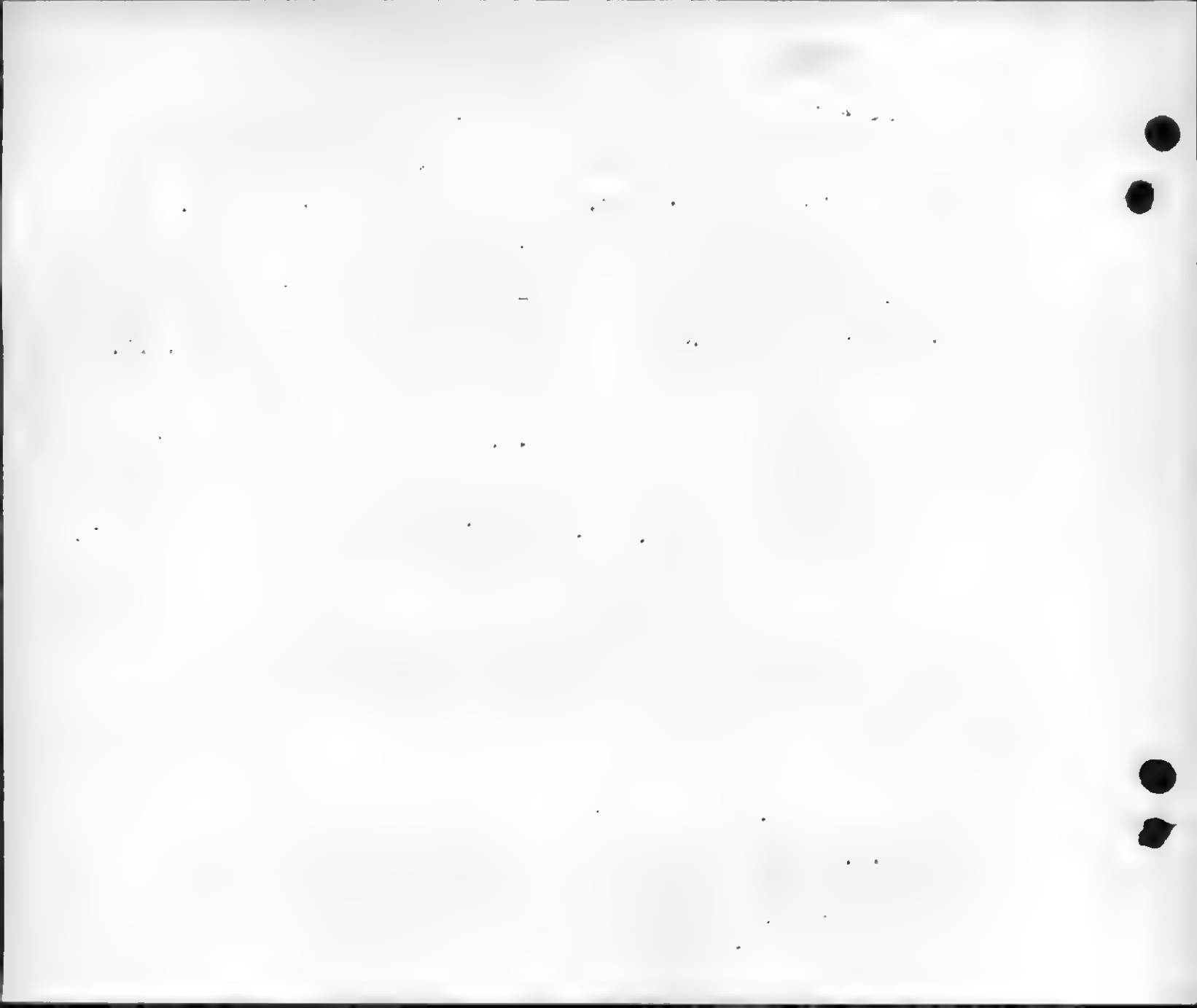
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights		c. LENGTH OF STAY IN 1b Month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Windabona Convalescent and Rest Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson, Maryland X	
d. STREET ADDRESS Jefferson		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last THERESA Virginia FRY		4. DATE OF DEATH Month Day Year February 28, 1961	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1977
9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (State or foreign country) Burkit,sville,Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Fox		14. MOTHER'S MAIDEN NAME Mildred Turner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Mildred A Fry, Jefferson, Maryland.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 32X DUE TO Subacute Pneumonia (b) Cerebral Thrombosis (c) Advanced generalized Arteriosclerosis 5 yr Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 7 days 3 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 27, 1961, to Feb. 28, 1961, that (I) (we) last saw the deceased alive on Feb. 27, 1961, and that death occurred at 11:00 A. M. from the causes and on the date stated above.			
22a. SIGNATURE A. T. Brice M.D.		22b. DATE SIGNED 2/28/61	
22c. PHYSICIAN'S NAME (Type) A. T. Brice, M.D.		22d. ADDRESS Jefferson, Maryland	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		23b. DATE THEREOF March 2, 1961	
23c. NAME OF CEMETERY OR CREMATORY St. Pauls Lutheran		23d. LOCATION (City, town, or county) (State) Jefferson, Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son, 106 E. Church St. Frederick, Maryland.		25a. REC'D BY REGISTRAR DATE MAR 3 '61	
25b. REGISTRAR'S SIGNATURE			



CERTIFICATE OF DEATH

Reg. Dist. No. 01803

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1888 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01864

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
c. LENGTH OF STAY IN 1b Lifetime		d. STREET ADDRESS 419 South Market Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 300 Block East Third St.			
3. NAME OF DECEASED (Type or print) Melvin S. Geisinger		4. DATE OF DEATH February 2, 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11, 1898
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employed at Ox Fibre Brush Co.		10b. KIND OF BUSINESS OR INDUSTRY Frederick, Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Daniel Geisinger		14. MOTHER'S MAIDEN NAME Katie R. Getzandanner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 579-14-9026	
17. INFORMANT Mrs. Florence B. Geisinger		Address 419 S. Market St. Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute heart failure			
(b) Healed myocardial infarct			
(c) Arterio sclerotic heart disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. B. O. Thomas, Sr.		M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 4, 1961	
22c. NAME OF CEMETERY OR CREMATORY Mount Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Littlestown, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Gailley Jr.		24a. REC'D BY REGISTRAR Frederick, Maryland	
24b. REGISTRAR'S SIGNATURE Robert E. Gailley Jr.		DATE FEB 6 1961	



1889

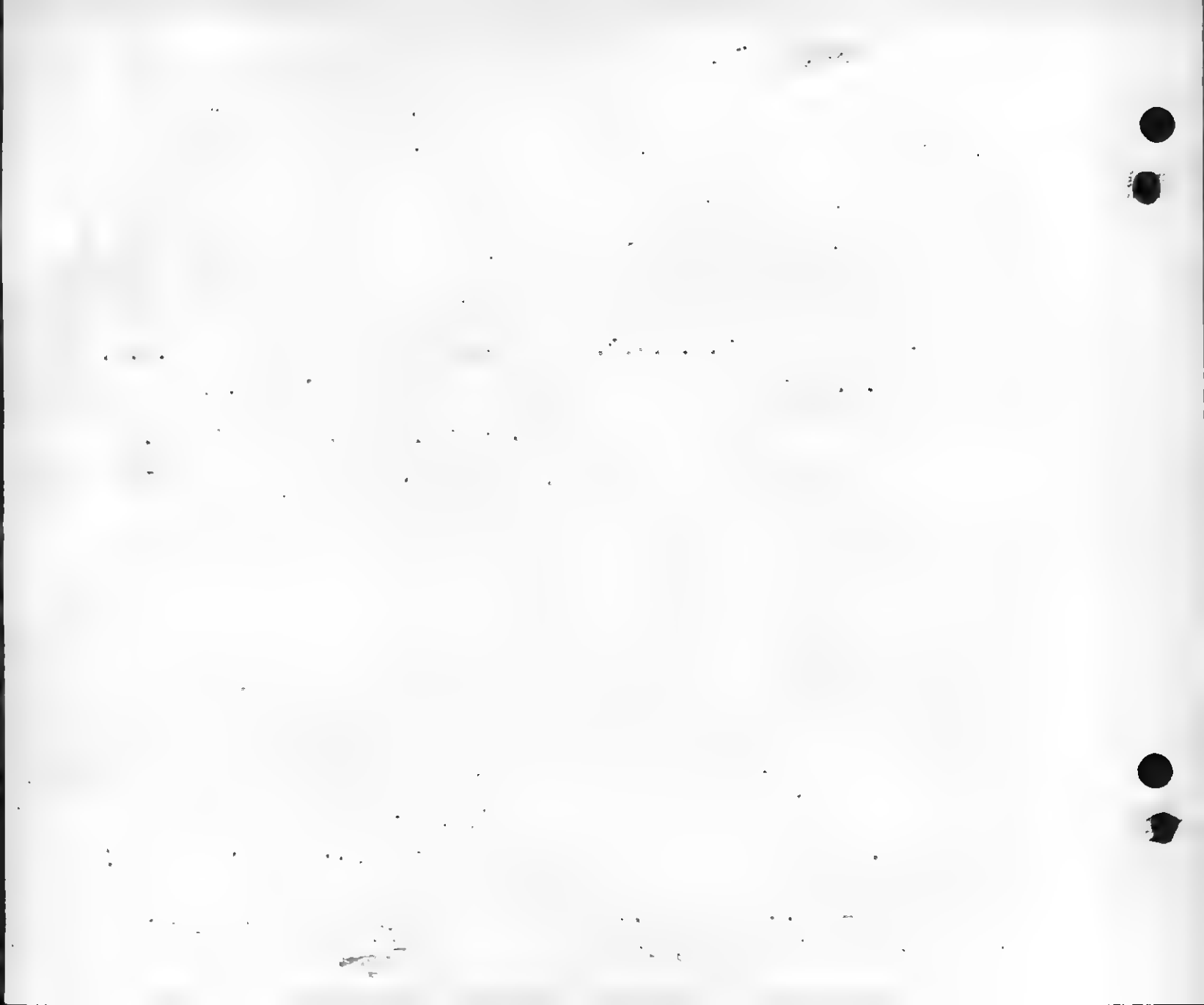
CERTIFICATE OF DEATH

Reg. Dist. No.

01865

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knoxville		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mountain Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James William Giles		4. DATE OF DEATH Month Day Year 2 8 1961	
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-29-1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transfer		10b. KIND OF BUSINESS OR INDUSTRY B.&O.R.R.Co	9. AGE (In years last birthday) 68 70
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J.H.Giles		14. MOTHER'S MAIDEN NAME Nollie Nightengale	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. INFORMANT Mrs. Mary E. Giles, Knoxville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 231X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 38 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-7-1961 to 2-8-1961 , that I last saw the deceased alive on 2-8-1961 , and that death occurred at 5:55 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE C.E. Pruitt		DATE SIGNED 2-9-61	
PHYSICIAN'S NAME (Type) C.E. Pruitt		ADDRESS (Street, city or town, state) Brunswick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-11-1961	22c. NAME OF CEMETERY OR CREMATORY Mountain	22d. LOCATION (City, town, or county) (State) Knoxville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. H. Fule		24a. REC'D BY REGISTRAR FEB 15 '61	
ADDRESS Brunswick, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



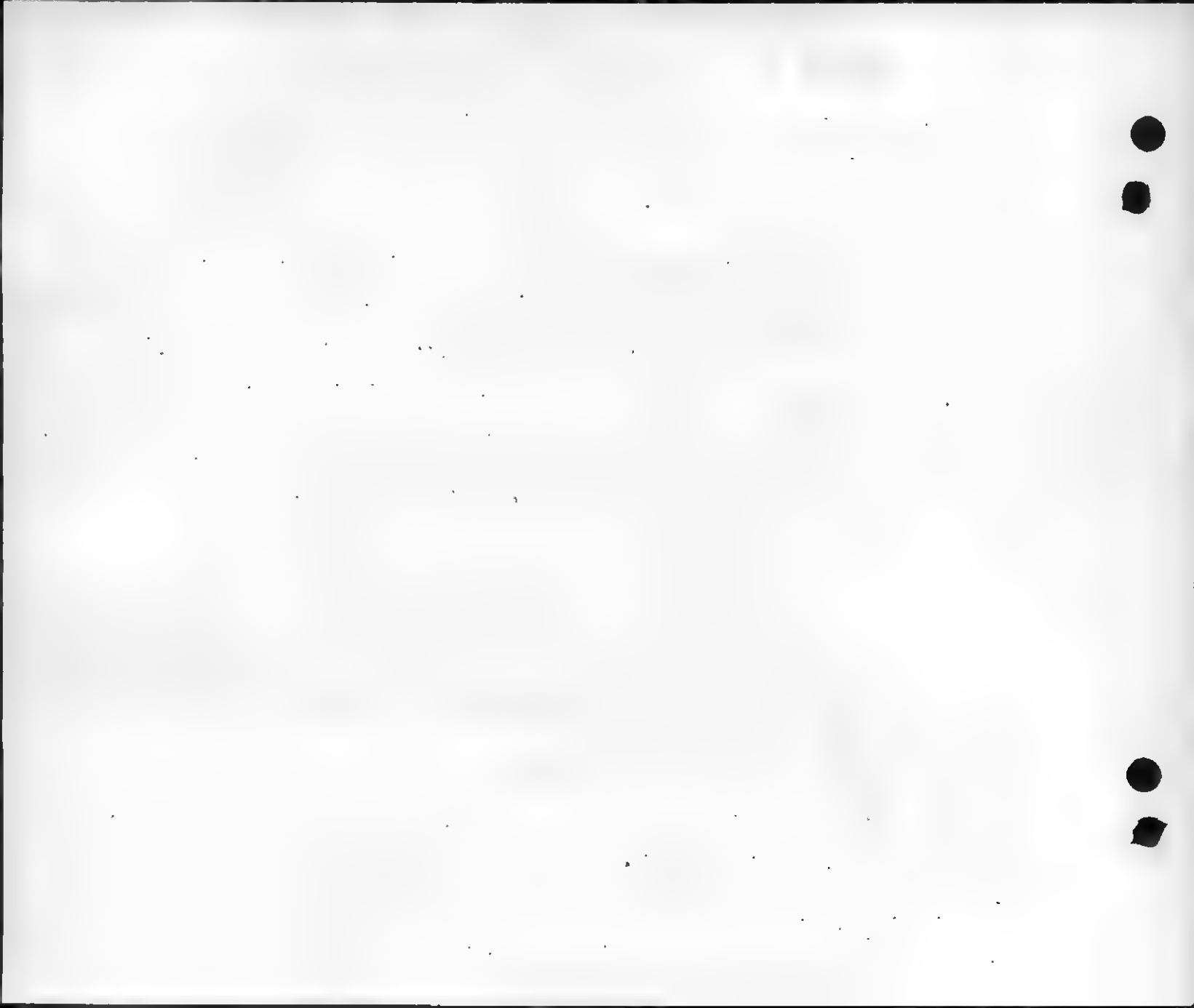
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01866

1890

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>				c. LENGTH OF STAY IN 1b <u>9 MONTHS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>MONTEVIEW HOME</u>				d. STREET ADDRESS <u>MONTEVIEW</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDITH GRACE GROSSNICK</u>				4. DATE OF DEATH <u>FEB. 12</u> 19 <u>61</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT 14-1891</u>	
9. AGE (In years last birthday) <u>69</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>ISAAC P STITELY</u>				14. MOTHER'S MAIDEN NAME <u>HARRIETT BELLESON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO <u>218-24-1743A</u>			
17. INFORMANT <u>MARGARET NICODEMUS</u> Address <u>MD UNION BRIDGE</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>545.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 5 minutes</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 8</u> , 19 <u>56</u> to <u>Feb 8</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Feb 8</u> , 19 <u>61</u> , and that death occurred at <u>4</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H.F. Kline</u> M.D.				ADDRESS (Street, city or town, state) <u>FREDERICK Md.</u> DATE SIGNED <u>FEB 12 61</u>			
PHYSICIAN'S NAME (Type) <u>H.F. KLINE MD</u>				<u>FREDERICK MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/15/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEAVER DAM</u>		22d. LOCATION (City, town, or county) (State) <u>FREDERICK CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DR. H. J. JACKSON</u> ADDRESS <u>UNION BRIDGE MD</u>				24a. REC'D BY REGISTRAR <u>FEB 16 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01862

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY **Frederick**

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Knoxville-Rural RD#1

c. LENGTH OF STAY IN 1b

30 Minutes

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)

a. STATE **Maryland**

b. COUNTY **Frederick**

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

d. STREET ADDRESS

121 East Patrick Street

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First **MICHAEL**

Middle **ARNOLD**

Last **HEMP**

4. DATE OF DEATH

Month **February** Day **21** Year **19 61**

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

3 April 1882

9. AGE (In years last birthday)

78 yrs

10. IF UNDER 1 YEAR

Months **0** Days **0**

11. IF UNDER 24 HRS

Hours **0** M n. **0**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Self-employed

10b. KIND OF BUSINESS OR INDUSTRY

Live Stock Dealer

11. BIRTHPLACE (State or foreign country)

Petersville, Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Peter S. Hemp

14. MOTHER'S MAIDEN NAME

Mary Catherine Arnold

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO

360-22-6937

17. INFORMANT

Mrs. Mary C. Hemp (Same as item #2)

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH
Minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

Arteriosclerosis and Hypertension

Years

DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY

Month, Day, Year
Hour **0** a. m. **19** p. m.

20d. INJURY OCCURRED

While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE

B. O. Thomas

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

22 Feb 1961

22a. BURIAL CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

2-24-61

22c. NAME OF CEMETERY OR CREMATORY

Mount Olivet Cemetery

22d. LOCATION (City, town, or county)

Frederick, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

M. R. Etchison & Son, Frederick, Maryland

ADDRESS

24a. REC'D BY REGISTRAR

FEB 23 '61

DATE

24b. REGISTRAR'S SIGNATURE

Carlton S. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

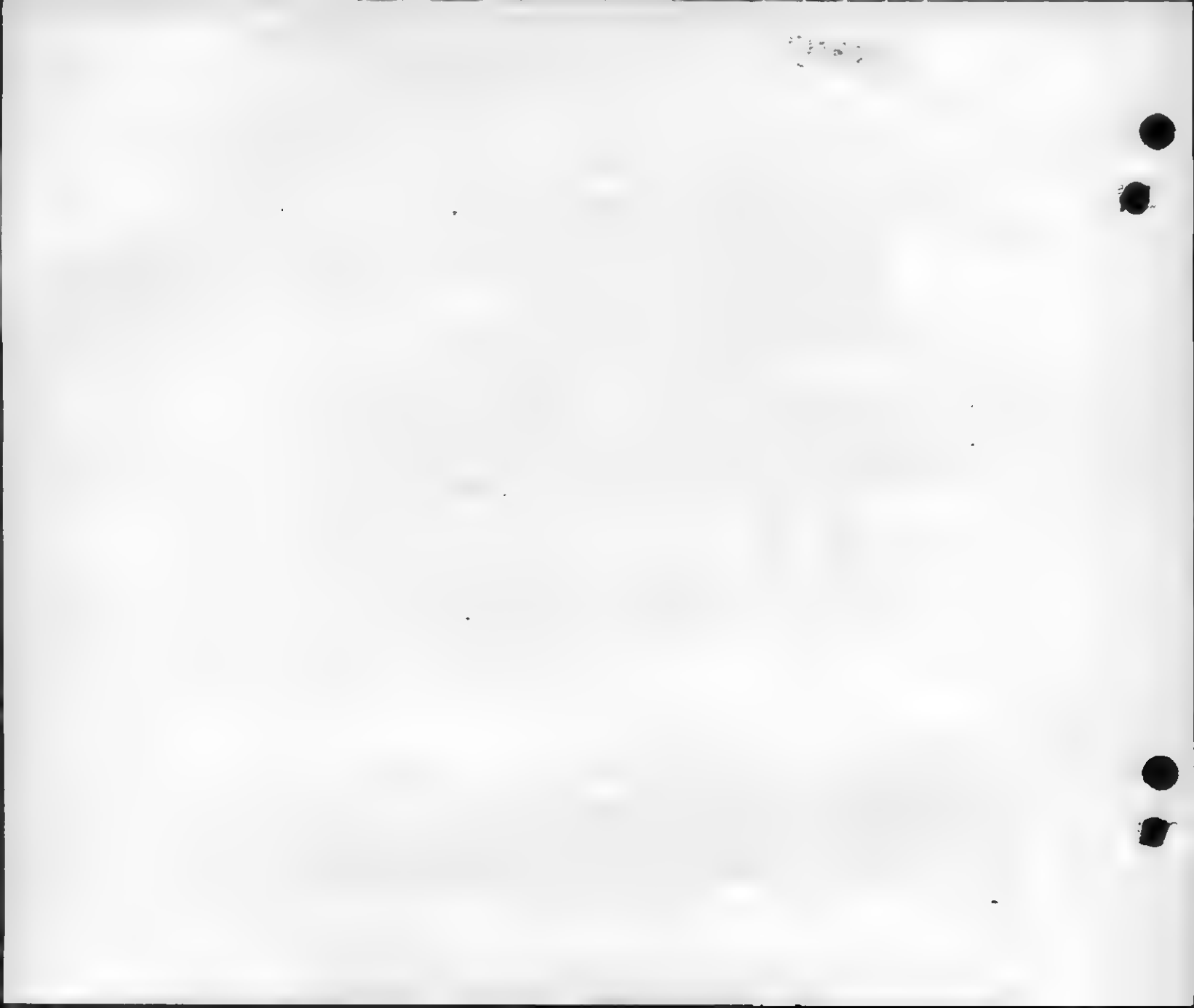
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1892

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01868

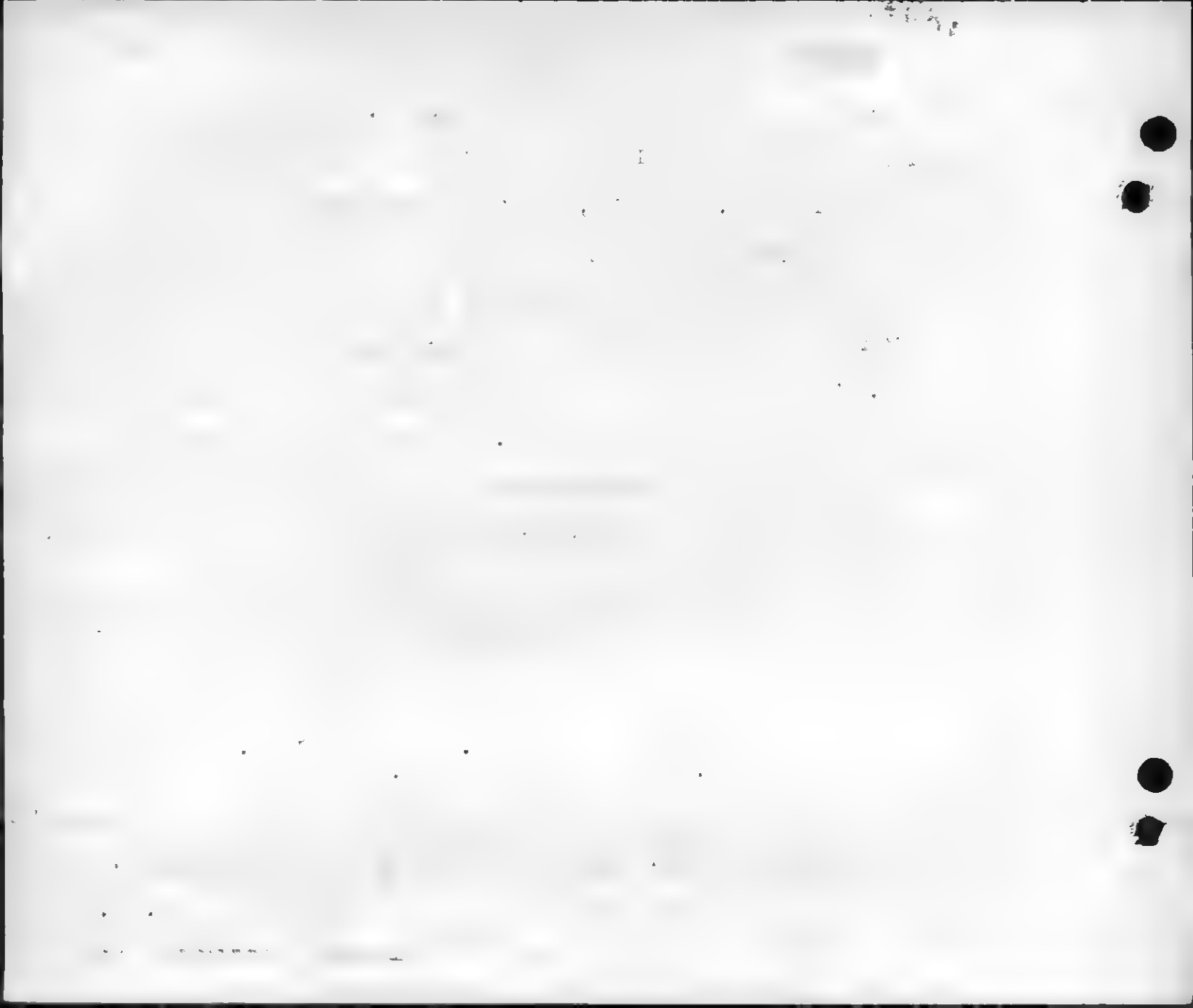
1 PLACE OF DEATH a. COUNTY Frederick MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital		d. STREET ADDRESS 1 E. Baltimore Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Agnes Bertha Hill		4. DATE OF DEATH Month 2 Day 14 Year 9 61	
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11/7/1884
9 AGE (In years lost birthday) 76 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Wesley Tippitt		14. MOTHER'S MAIDEN NAME Appie Hancock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17 INFORMANT Record of Victor Cullen Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis 002 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease - 420		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 1/5 1961 to 2/14 1961, that (I) (we) last saw the deceased alive on 2/14 1961 and that death occurred at 12 PM, from the causes and on the date stated above.			
22a. SIGNATURE Michael G. Zavis M.D.		22b. DATE SIGNED 2/14/1961	
22c. PHYSICIAN'S NAME (Type) Michael G. Zavis, M.D.		22d. ADDRESS Cullen, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/16/61	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Green		23d. LOCATION (City, town, or county) Hagerstown Md (State)	
24 FUNERAL DIRECTOR'S SIGNATURE H. H. Hoffman Hagerstown Md.		25a. REC'D BY REGISTRAR DATE FEB 20 '61	
		25b. REGISTRAR'S SIGNATURE Arthur L. Turner	



1893
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01869

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE West Va. b. COUNTY Kanawha	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nitro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Walter Reed General Hosp. Ft Detrick, Md		d. STREET ADDRESS 2707 27th Street	
3. NAME OF DECEASED (Type or print) First FREDERICK Middle C. Last HILL		4. DATE OF DEATH Month Feb Day 17 Year 1961	
5 SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 Sep 1932
9. AGE (In years last birthday) 28 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Military		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Fred R. Hill		14. MOTHER'S MAIDEN NAME Gratta Wooddell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 232-506815	
17. INFORMANT Address Mrs. Catherine Hill Wife same as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) Pulmonary edema 201X DUE TO Hodgkins Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS A POSTMORTEM PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 7 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 30 Jan. 1961 to 17 Feb. 1961 that (I) (we) last saw the deceased alive on 17 Feb. 1961 , and that death occurred at 8:10 A.M. from the causes and on the date stated above			
22a. SIGNATURE		22b. DATE SIGNED 17 Feb 1961	
22c. PHYSICIAN'S NAME (Type) S. Kress		22d. ADDRESS USA Medical Unit, Ft Detrick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 2-18-61	
23c. NAME OF CEMETERY OR CREMATORY Cunningham		23d. LOCATION (City, town, or county) (State) St Albans W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Daily Jr.		25a. REC'D BY REGISTRAR Harold C. L. L. L.	
25b. REGISTRAR'S SIGNATURE Arthur L. Kress		DATE 17 Feb 61	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1894

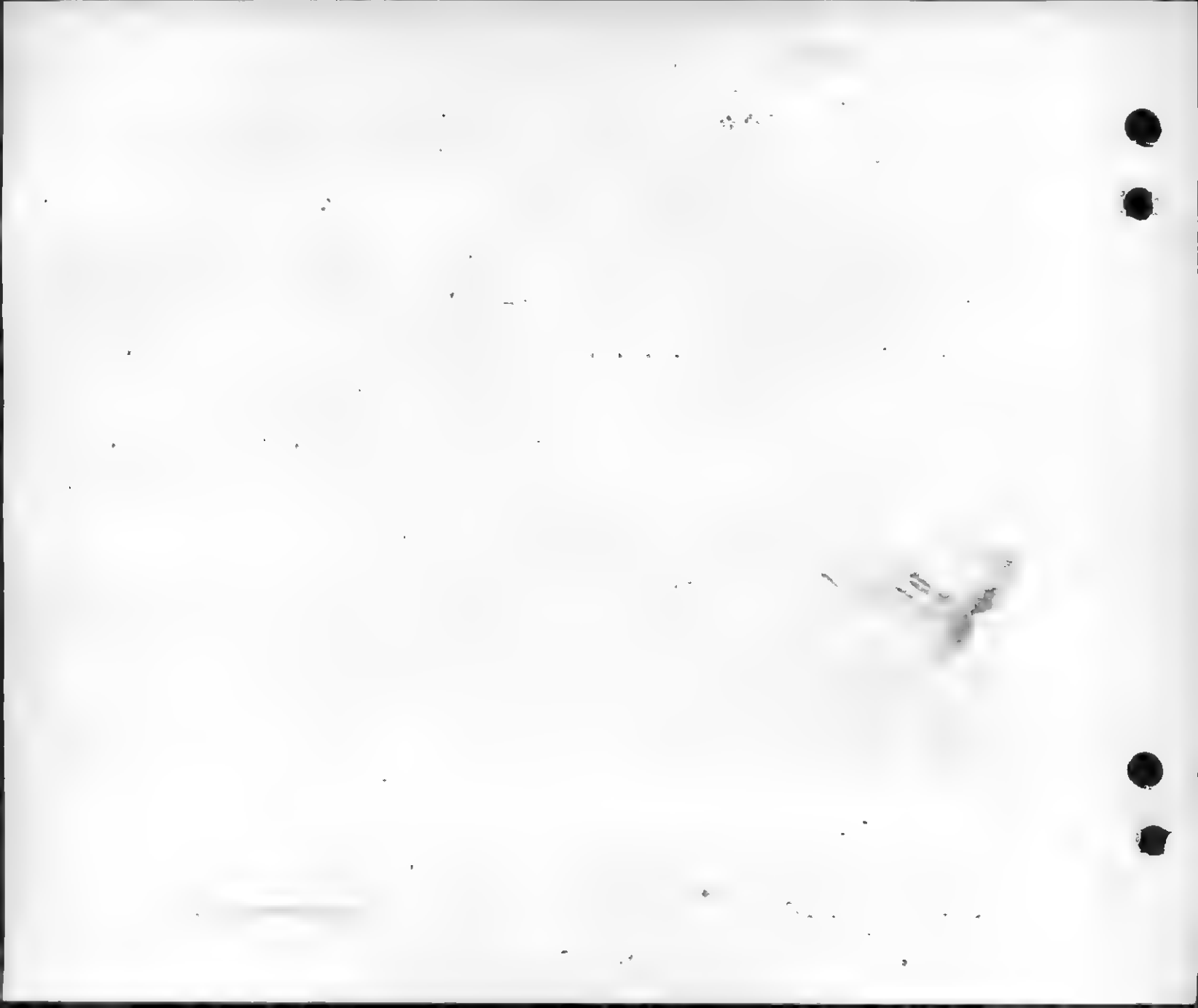
CERTIFICATE OF DEATH

Reg. Dist. No.

01870

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 325 Walnut Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Winfield Last Kelley		4. DATE OF DEATH Month 2 Day 8 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-19-1867
9. AGE (In years last birthday) yrs 93		10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Trainman		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R. R. Co	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Miss Ivadore Kelley, Brunswick, Md.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Congestive Heart Failure DUE TO (c) Prostatic Hypertrophy		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs. 1 yr 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 10, 1960 to Feb. 7, 1961 , that I last saw the deceased alive on Feb. 7, 1961 , and that death occurred at 10:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature]		DATE SIGNED Feb. 10, 1961	
PHYSICIAN'S NAME (Type) C. M. Byron Keo, M.D.		ADDRESS (Street, city or town, state) Gum Spring Hollow, Brunswick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-11-1961	
22c. NAME OF CEMETERY OR CREMATORY Reformed		22d. LOCATION (City, town, or county) (State) Brunswick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS Brunswick, Maryland	
24a. REC'D BY REGISTRAR FEB 15 '61		24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director.
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

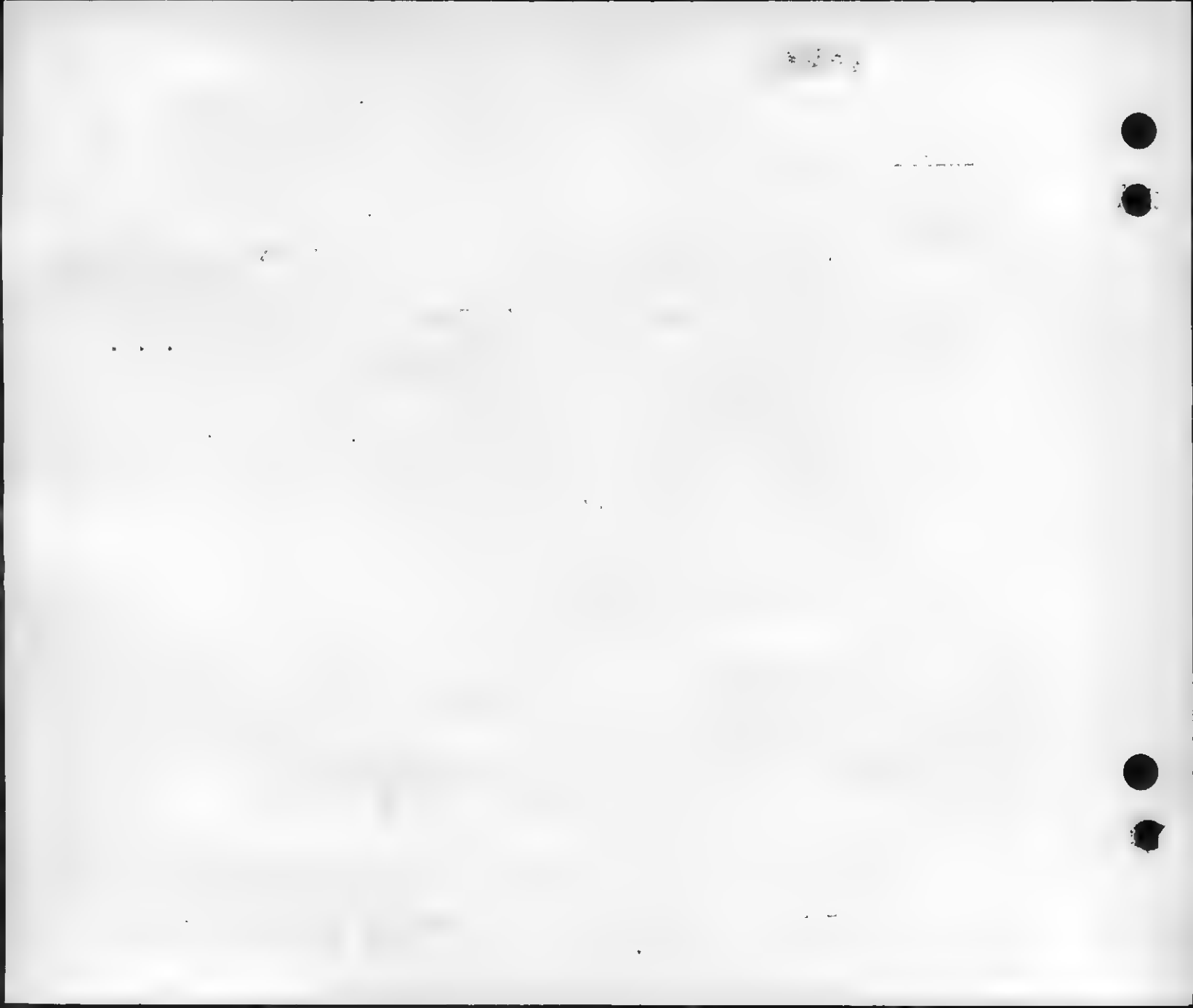
VR AIS (4)
ISM 9/59

1895
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01871

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.F.D.#6	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS Near Jug Bridge	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CARROLL WALLACE KENT		4. DATE OF DEATH Month Day Year February 3, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1883
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm-Owner		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Phinias M. Kent		14. MOTHER'S MAIDEN NAME Jenny Wallace	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-36-4253	
17. INFORMANT Mrs. Fern H. Kent- Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anemia - Secondary (c) Intestinal Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 1 yr 1 yr 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intestinal Hypodysplasia		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1957 to Feb 3, 1961, that (I) (we) last saw the deceased alive on Feb 3, 1961, and that death occurred at 2:30 PM, from the causes and on the date stated above			
22a. SIGNATURE Thomas E. Stone M.D.		22b. DATE SIGNED 2/7/1961	
22c. PHYSICIAN'S NAME (Type) Thomas E. Stone, M.D.		22d. ADDRESS West Third Street, Frederick, Maryland	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 7, 1961	
23c. NAME OF CEMETERY OR CREMATORY Frederick Memorial Park		23d. LOCATION (City, town, or county) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR DATE FEB 9 '61	
		25b. REGISTRAR'S SIGNATURE O. L. S. Evans	





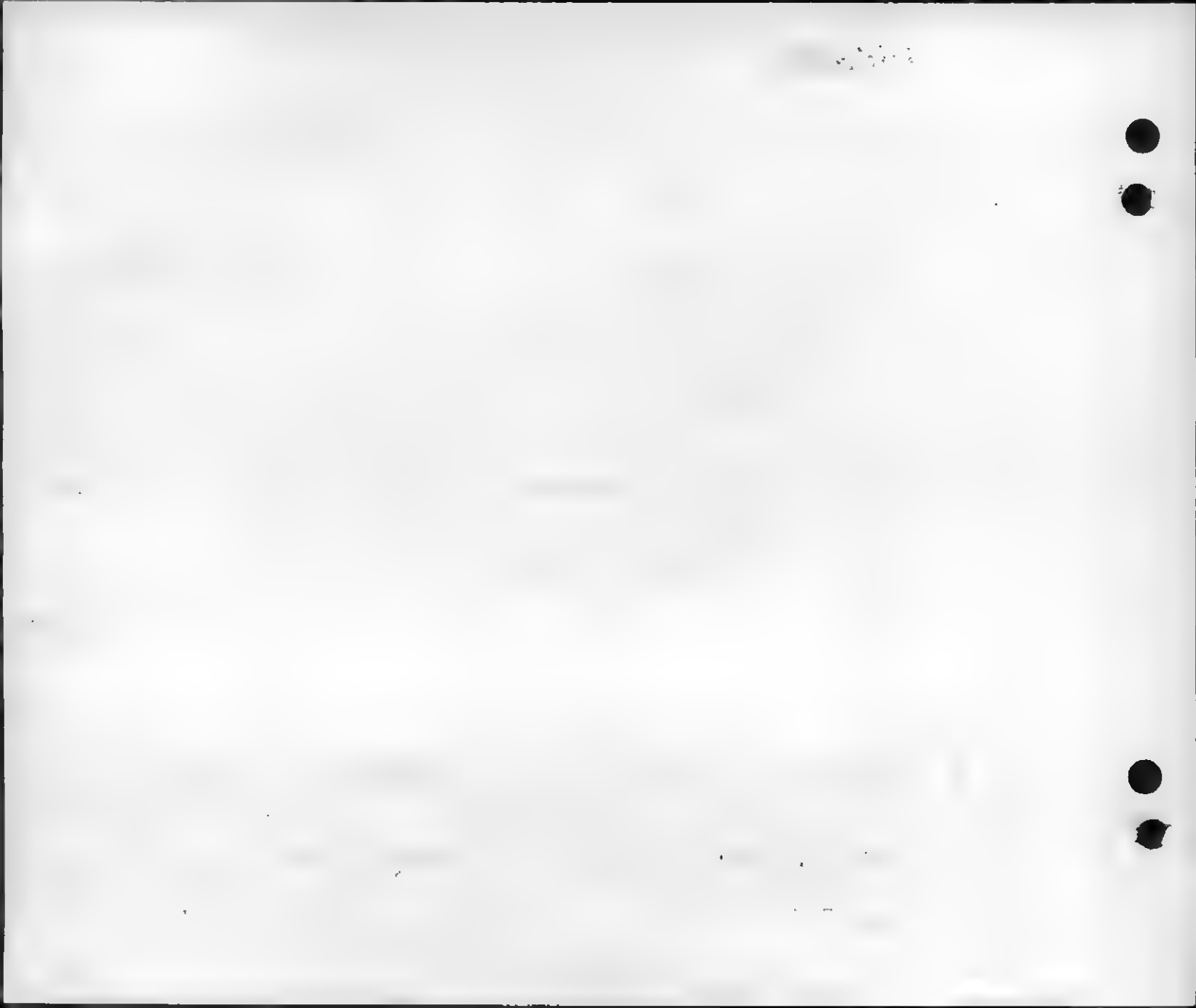
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
1897
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01873

1 PLACE OF DEATH a. COUNTY FREDERICK MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Tenn b. COUNTY Robertson	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springfield	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WARD 200 WRGH		d. STREET ADDRESS Greenbrier Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Martha Middle B Last Maxwell		4. DATE OF DEATH Month Feb Day 25 Year 1961	
5 SEX Female	6. COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8 Dec. 1934
9. AGE (In years last birthday) 26 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY N-A	
11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Robert F Bibb		14. MOTHER'S MAIDEN NAME Elizabeth Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16 SOCIAL SECURITY NO. 21 James L Maxwell Springfield Tenn	
17. INFORMANT 21 James L Maxwell Springfield Tenn		Address P.O. Box 468	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 201X DUE TO ARREST HODGKINS DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO HODGKINS DISEASE (c) HODGKINS DISEASE		INTERVAL BETWEEN ONSET AND DEATH 22 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): NONE		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 23 JAN 1961 to 25 FEB 1961 , that (I) (we) last saw the deceased alive on 25 FEB 1961 and that death occurred at 6 PM , from the causes and on the date stated above.			
22a SIGNATURE David W. Grauman		22b DATE 25 Feb 1961	
22c. PHYSICIAN'S NAME (Type) DAVID W. GRAUMAN		22d ADDRESS Ward 200 WRGH	
23a BLR AL CREMATION REMOVAL (Specify) Removal		23b DATE THEREOF 2-27-61	
23c. NAME OF CEMETERY OR CREMATORY St. Charles		23d. LOCATION (City, town, or county) (State) Springfield, Tenn.	
24 FUNERAL DIRECTOR'S SIGNATURE MR. Arthur L. Kinnick		25a. REC'D BY REGISTRAR FEB 28 '61	
ADDRESS St. Charles		25b REGISTRAR'S SIGNATURE Arthur L. Kinnick	

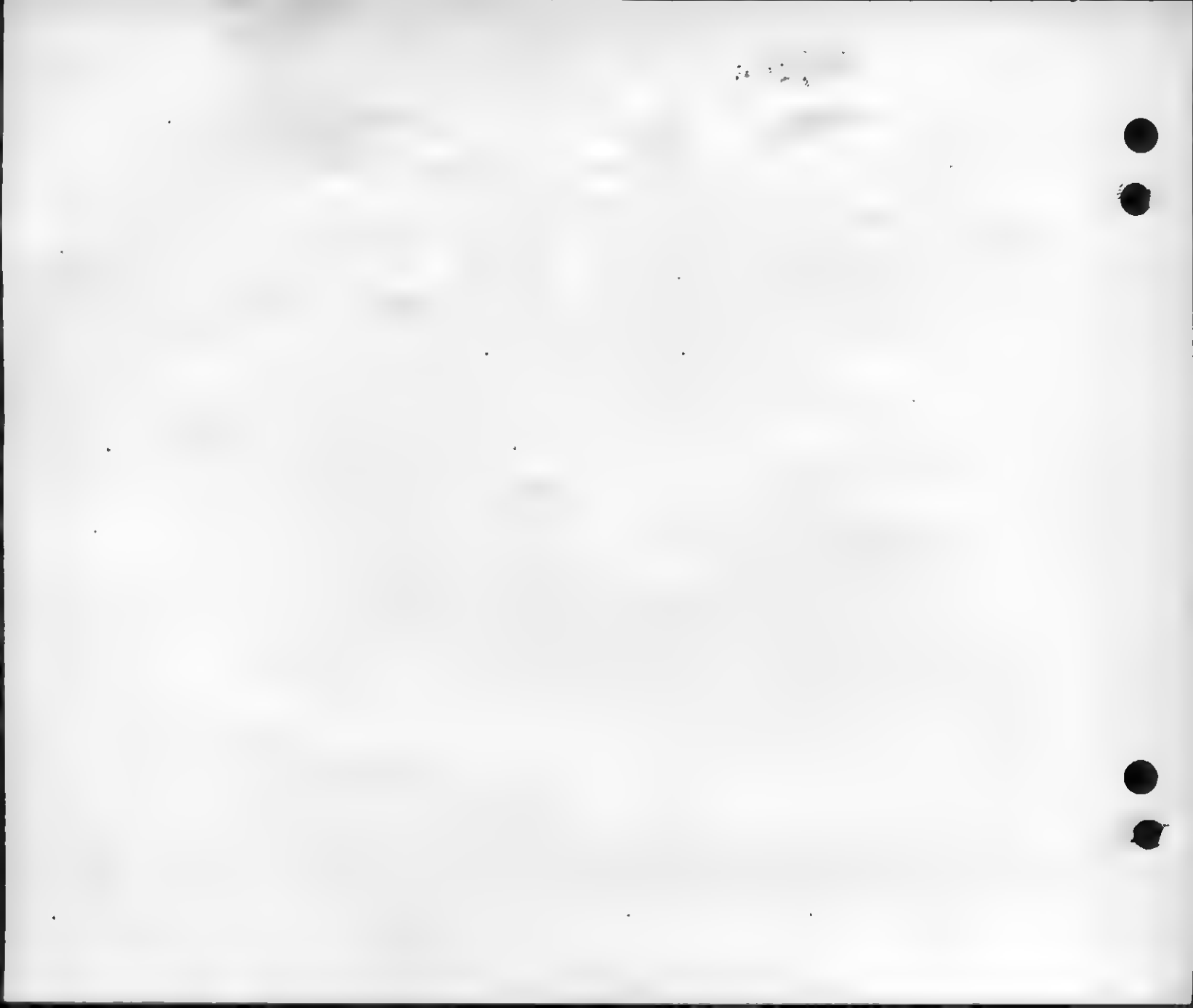


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1898

01874

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Route 3 - Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Calvin Last McKee			4. DATE OF DEATH Month 2 Day 9 Year 1961				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1992 6-9-1898		9. AGE (In years last birthday) 68 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Foreman				10b. KIND OF BUSINESS OR INDUSTRY Fred. Co. Roads Dept. Maryland		11. BIRTHPLACE (State or foreign country) United States	
13. FATHER'S NAME Allen McKee				14. MOTHER'S MAIDEN NAME Ida Summers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO 214-09-2052		17. INFORMANT Mrs. Harold Keller, Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 227-1 (b) Pulmonary emphysema, fibrosis and atelectasis (c) atelectasis							INTERVAL BETWEEN ONSET AND DEATH 2 days yrs.
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Healed Posterior Myocardial Infarct							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 8, 1961 to Feb. 9, 1961 , that (I) (we) last saw the deceased alive on Feb. 9, 1961 , and that death occurred at 1:00 AM , from the causes and on the date stated above							
22a. SIGNATURE Henry V. Chase				22b. DATE SIGNED 2-9-61		22c. PHYSICIAN'S NAME (Type) HENRY V. CHASE	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 11, 1961		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Lutheran		23d. LOCATION (City, town, or county) (State) Myersville, Fred. Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle				25a. RECEIVED BY REGISTRAR 1461		25b. REGISTRAR'S SIGNATURE Arthur L. Krasna	

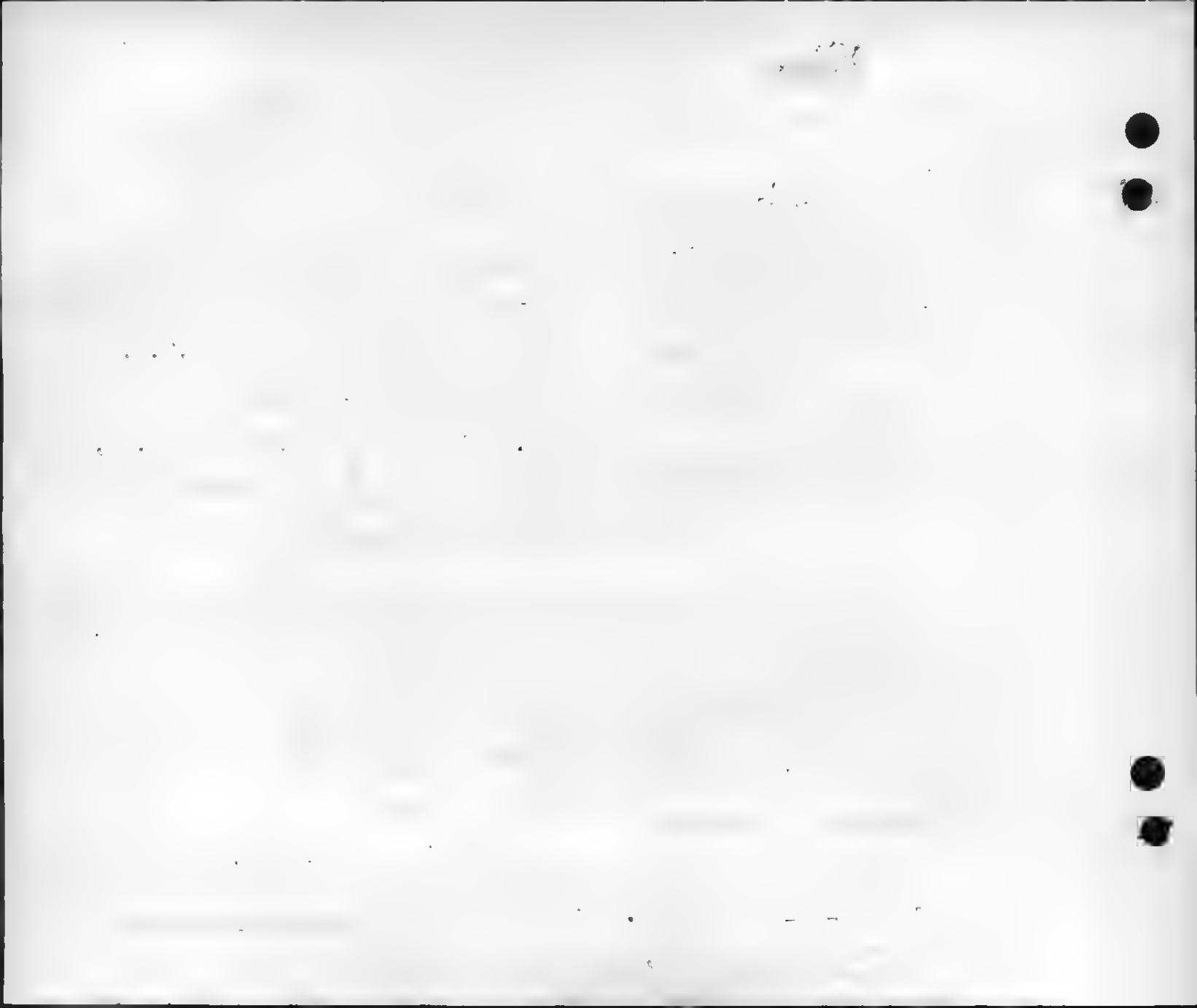


TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1899
CERTIFICATE OF DEATH

01870

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb Brunswick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lillian Viola McWilliams		4. DATE OF DEATH Feb 17 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-3-1900
9. AGE (in years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 1 Days 17 Hours 12 Min.	11. IF UNDER 24 HRS Hours 12 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Painter		14. MOTHER'S MAIDEN NAME Sadie Livingston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Vivian Daugherty, Brunswick, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis with ascites DUE TO (b) adenocarcinoma of the ovary DUE TO (c) lymphoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 6 mo. 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1956 , to Feb 17 1961 , that (I) (we) last saw the deceased alive on Feb 17 1961 , and that death occurred at 11 P.M. from the causes and on the date stated above			
22a. SIGNATURE Henry V. Chase		22b. DATE SIGNED 2/18/61	
22c. PHYSICIAN'S NAME (Type) Henry V. Chase		22d. ADDRESS 4 E. Church St. Frederick Md	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 2-21-1961	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet		23d. LOCATION (City, town, or county) (State) Frederick Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kinn		25a. REC'D BY REGISTRAR DATE FEB 23 '61	
ADDRESS Brunswick, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Kinn	



018710

MEDICAL CERTIFICATION

C. E. Wilson



1901

CERTIFICATE OF DEATH

Reg. Dist. No. 01872

1. PLACE OF DEATH o. COUNTY <u>Frederick</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>1 hr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Frederick Memorial Hospital</u>				d. STREET ADDRESS <u>Rural, Walkersville</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY BENJAMIN MORGAN</u>				4. DATE OF DEATH Month Day Year <u>Feb. 9 1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 21 1906</u>	
9. AGE (In years last birthday) <u>54</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>B. Frank Morgan</u>				14. MOTHER'S MAIDEN NAME <u>Daisy Lane</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-18-0642</u>		17. INFORMANT <u>Mrs. Harry Morgan, Walkersville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial asthma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary emphysema 10 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Jan 9 1961</u> to <u>Feb 9 1961</u> , that I last saw the deceased alive on <u>9 February 1961</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>WALKERSVILLE, Md.</u>				DATE SIGNED <u>11 Feb 61</u>			
ACTUAL SIGNATURE <u>James E. Stoner, Jr.</u>				M.D. <u>WALKERSVILLE, Md.</u>			
PHYSICIAN'S NAME (Type) <u>JAMES E. STONER, JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 13, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>M. Libertytown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Y. C. Barton, Walkersville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 14 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after the death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1902

CERTIFICATE OF DEATH

Reg. Dist. No.

01878

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WALKERSVILLE		c. LENGTH OF STAY IN 1b 2 Yr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WALKERSVILLE	
		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First FANNIE Middle REBECCA Last MUSSER		4. DATE OF DEATH Month 2 Day 25 Year 19 61	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug, 18th 1882
		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wif.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME CHARLES D. BURRIER		14. MOTHER'S MAIDEN NAME CATHERINE HOKE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown)		16. SOCIAL SECURITY NO	
		17. INFORMANT MOMROE MUSSER Address Charing Cross Rd, Balto 29 Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis & acute myocardial infarction 420.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease 10 years			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dilated cardiomyopathy 2 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 23 Feb , 19 61 , to 25 Feb , 19 61 , that I last saw the deceased alive on 24 Feb , 19 61 , and that death occurred at 6:45 A.M. from the causes and on the date stated above.			
ACTUAL James E. Stoner Jr. M.D.		ADDRESS (Street, city or town—state) Walkersville Md DATE SIGNED 2/25/61	
PHYSICIAN'S NAME (Type) James E. Stoner Jr			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/28/61	22c. NAME OF CEMETERY OR CREMATORY Mt Olivet	22d. LOCATION (City, town, or county) (State) F rederick MD
23. FUNERAL DIRECTOR'S SIGNATURE W. C. Barton		24a. REC'D BY REGISTRAR DATE FEB 28 '61	24b. REGISTRAR'S SIGNATURE Caroline L. Kunk

TO HOSPITAL: The attending physician: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1903

CERTIFICATE OF DEATH

Reg. Dist. No. 0187

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> X	
c. LENGTH OF STAY IN 1b <u>1 Month</u>		d. STREET ADDRESS <u>15 W. All Saints Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>15 W. All Saints Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ollie</u> Middle <u>Edward</u> Last <u>Naylor</u>		4. DATE OF DEATH Month <u>February</u> Day <u>12</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 15-1901</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Frederick, Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charlie E. Naylor</u>		14. MOTHER'S MAIDEN NAME <u>Addie Louise Brooks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>Nellie Holland-15 W. All Saints St.</u>		Address <u>Frederick, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the stomach - ? primary in stomach</u> DUE TO <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4.5 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>0815</u> 19 <u>60</u> , to <u>0712</u> 19 <u>61</u> , that I last saw the deceased alive on <u>7-5</u> 19 <u>61</u> , and that death occurred at <u>4:35</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Market Street-Frederick, Md.</u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>Bob Martin</u> M.D.		PHYSICIAN'S NAME (Type) <u>Bob Martin</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-13-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.B. Hicks 111</u> ADDRESS <u>Frederick, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 20 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2-2-1944

2-2-1944

1
1904
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01860

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 607 Rosemont Avenue		d. STREET ADDRESS 607 Rosemont Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROBERT Middle FULTON Last NICODEMUS, SR.		4. DATE OF DEATH Month February Day 25 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1900
9. AGE (In years last birthday) 60		10. IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President		10b. KIND OF BUSINESS OR INDUSTRY Ice Cream Company	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME A. W. Nicodemus, Jr.		14. MOTHER'S MAIDEN NAME Annie Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-3189	
17. INFORMANT Mrs. Elizabeth K. Nicodemus-Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Angina Pectoris DUE TO (b) Arterio-sclerotic coronary art. dis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (c), stating the underlying cause last. 18 mos. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema - Chronic INTERVAL BETWEEN ONSET AND DEATH 18 mos.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1949 to 2/25/61 , that (I) (we) last saw the deceased alive on 25 Feb. 1961 , and that death occurred 10:15P from the causes and on the date stated above.			
22a. SIGNATURE Charles H. Conley, Jr.		22b. DATE SIGNED 2/28/1961	
22c. PHYSICIAN'S NAME (Type) Charles H. Conley, Jr., M.D.		22d. ADDRESS Professional Building, Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb. 28, 1961	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION (City, town, or county) (State) Frederick, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR DATE MAR 1 '61	
25b. REGISTRAR'S SIGNATURE William L. Hume			

MEDICAL CERTIFICATION



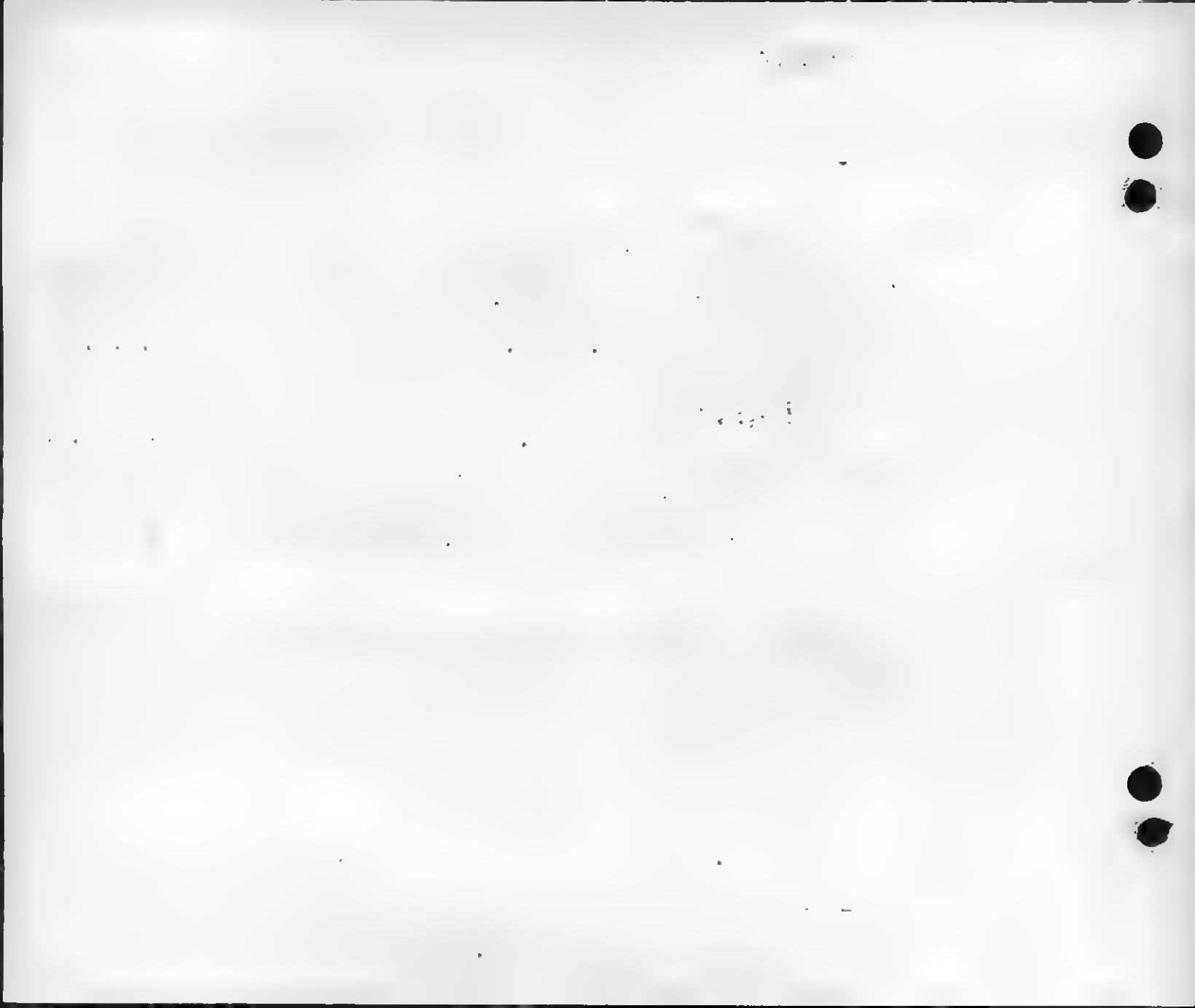
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1905 CERTIFICATE OF DEATH

01861

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admision) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont rural				c. LENGTH OF STAY IN lb Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Edward Last Nunemaker				4. DATE OF DEATH Month February Day 20 Year 19 61			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 21, 1875	
9. AGE (In years last birthday) yrs. 85		10. IF UNDER 1 YEAR Months 8 Days 5 Hours 15 Min.		11. IF UNDER 24 HRS Months 8 Days 5 Hours 15 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teamster				10b. KIND OF BUSINESS OR INDUSTRY Old Cat. Furn.			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Jacob Nunemaker				14. MOTHER'S MAIDEN NAME Sarah Ann Jamison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Card lost		17. INFORMANT Mrs. Herbert Sweeney Address Thurmont, Md. RD1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart disease, arteriosclerotic type 20c. DUE TO Arteriosclerosis, generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized (c) Arteriosclerosis, generalized							INTERVAL BETWEEN ONSET AND DEATH 6 mos 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a m p m 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 15, 1960 to Feb. 20, 1961 , that (I) (we) last saw the deceased alive on Jan. 15, 1961 , and that death occurred at 8 AM , from the causes and on the date stated above							
22a. SIGNATURE James K. Gray				22b. DATE SIGNED Feb. 20, 1961			
22c. PHYSICIAN'S NAME (Type) James K. Gray				22d. ADDRESS Thurmont, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		2-23-61		Lewistown Cemetery		Lewistown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Thurmont, Md.				25a. REC'D BY REGISTRAR FEB 23 '61		25b. REGISTRAR'S SIGNATURE C. E. S. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1906 CERTIFICATE OF DEATH

0188c

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS 225 West Fifth Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First BENJAMIN Middle FRANKLIN Last PHEBUS				4. DATE OF DEATH Month February Day 16 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 22 Nov 1886		9. AGE (In years last birthday) 74 yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Regional Warden		10b. KIND OF BUSINESS OR INDUSTRY Inland Game & Fish		11. BIRTHPLACE (State or foreign country) Frederick, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Phebus				14. MOTHER'S MAIDEN NAME Elizabeth Fisher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 212-38-8655		17. INFORMANT Mrs. Daisy Y. Phebus (Same as item #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of bladder DUE TO (b) Generalized carcinomatous + Uremia DUE TO (c) Ureteral obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of prostate							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 21 Aug. 1960 to 16 Feb. 1961 , that (I) (we) last saw the deceased alive on 16 Feb. 1961 , and that death occurred at 8:10A M, from the causes and on the date stated above.							
22a. SIGNATURE Robert D. Crouch				M.D. ATTENDING PHYS. XX MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 17 Feb 1961	
22c. PHYSICIAN'S NAME (Type) Robert D. Crouch, M. D.				22d. ADDRESS 806 Toll House Ave., Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-20-61		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				25a. REC'D BY REGISTRAR DATE FEB 20 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kram	



1907

CERTIFICATE OF DEATH

Reg. Dist. No. 01883

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 5 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Walkersville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hosp.		d. STREET ADDRESS 12 Maple Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Roscoe Middle Hezekiah Last PORTS		4. DATE OF DEATH Month Feb. Day 19 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 13, 1919
9. AGE (In years last birthday) 42 yrs.		10. IF UNDER 1 YEAR Months 42 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store	
11. BIRTHPLACE (State or foreign country) Walkersville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Roscoe Hezekiah PORTS sr.		14. MOTHER'S MAIDEN NAME Ruth E. REDDICK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-07-5841	
17. INFORMANT Wife: Mrs. Ruth PORTS, Walkersville		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ruptured esophageal varices 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of liver DUE TO (c) Malnutrition		INTERVAL BETWEEN ONSET AND DEATH 5 days 5-10 yrs 5-10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral acute purulent otitis media		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 27 , 1961, to Dec. 19, 1961 , that I last saw the deceased alive on Feb. 18 , 1961, and that death occurred at 5:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frederick Shopping Center DATE SIGNED ACTUAL SIGNATURE Ralph L. Michels M.D. PHYSICIAN'S NAME (Type) Ralph L. Michels Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/21/61	
22c. NAME OF CEMETERY OR CREMATORY Int Hope Cem.		22d. LOCATION (City, town, or county) (State) Woodstock Md	
23. FUNERAL DIRECTOR'S SIGNATURE S.C. Barton, Walkersville, Md		24a. REC'D BY REGISTRAR DATE FEB 23 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01884

1908

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dickerson R.O.I.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dickerson R.O.I.</u>	
c. LENGTH OF STAY IN 1b <u>14 yrs</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Wesley Posey</u>		4. DATE OF DEATH <u>February 5</u> 19 <u>61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 14, 1886</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Posey</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Malvern</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mrs. Henderson--same 2d</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <u>491X</u> IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> Conditions, if any, which gave rise to immediate cause (b) <u>3 days</u> (c), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B. C. Thomas</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B. C. Thomas M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Feb. 5, 1961</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/8/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Potomac Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Potomac, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>Feb 9 '61</u>		24b. REGISTRAR'S SIGNATURE <u>C. W. S. Thomas</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home to be retained for your files. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1909

01885

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 20 Minutes			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. STREET ADDRESS Quynn Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First DONALD Middle FITEZ Last RAMSBURG				4. DATE OF DEATH Month February Day 5 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 10, 1917	
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0		11. IF UNDER 24 HRS Hours 0 Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Supt.				10b. KIND OF BUSINESS OR INDUSTRY Elect. Cont.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Roy H. Ramsburg				14. MOTHER'S MAIDEN NAME Lula Fitez			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 215-18-1911		17. INFORMANT Mrs. Doris L. Ramsburg, Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumococcus Meningitis DUE TO 5911.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Otitis media (right) DUE TO (c) 3 days				INTERVAL BETWEEN ONSET AND DEATH 12 hours 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6:45A	
20f. (City or town) (County) (State) Frederick, Maryland							
21. I certify that (I) (this hospital) attended the deceased from 2-12 19 61 to 2-15 19 61 , that (I) (we) last saw the deceased alive on 2-12 19 61 , and that death occurred on 2-15 19 61 , from the causes and on the date stated above.							
22a. SIGNATURE Louis R. Schoolman M.D.				22b. DATE SIGNED 2/6/1961			
22c. PHYSICIAN'S NAME (Type) Louis R. Schoolman, M.D.				22d. ADDRESS Poll House Ave., Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 8, 1961		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				25a. REC'D BY REGISTRAR DATE FEB 9 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01880

FOR STATE
HEALTH DEPT.

1910

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont R.F.D. I c. LENGTH OF STAY IN 1b 10 Yrs d. STREET ADDRESS 1		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont R.F.D. I d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Earl Carlton Ramsburg		4. DATE OF DEATH Month February Day 16 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1919
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months 1 Days 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Frederick County	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Ramsburg		14. MOTHER'S MAIDEN NAME Cora May Staub	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. Army 214-14-6992	
17. INFORMANT Mrs Pauline L. Ramsburg		Address Thurmont R.F.D. I	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hour			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B.O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B.O. Thomas, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 19, '61	
22c. NAME OF CEMETERY OR CREMATORY Utica Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Thurmont R.F.D. I Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Daily		24a. REC'D BY REGISTRAR FEB 20 '61	
ADDRESS Frederick, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Travis	



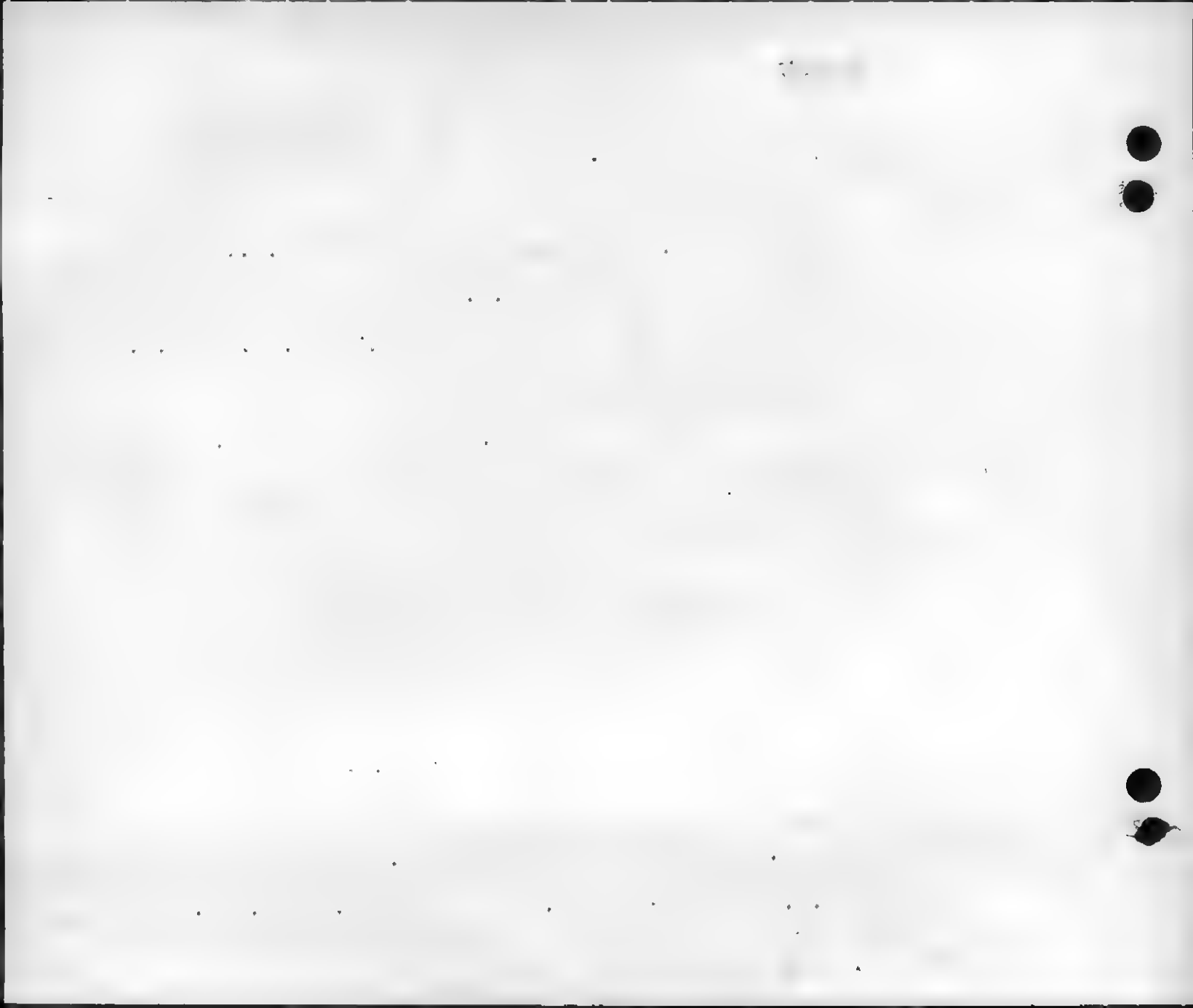
The law requires that the death certificate be executed within 24 hours after death. It may be refiled at a hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board at Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01887

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on: Residence before admission) a. STATE MD b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont		c. LENGTH OF STAY IN 1b 40 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont	
3. NAME OF DECEASED (Type or print) George First W. Middle Ramsburg Last		4. DATE OF DEATH Feb. 2..1961 Month Feb. Day 2 Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1975
9. AGE (In years last birthday) 85 yrs		10. IF UNDER 1 YEAR Months 8 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Thrasherman		10b. KIND OF BUSINESS OR INDUSTRY Own rig	
11. BIRTHPLACE (State or foreign country) Lewistown, Fredk. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Daniel Ramsburg		14. MOTHER'S MAIDEN NAME Savilla Baugher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NO	
17. INFORMANT Glenn M. Ramsburg Address Thurmont, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart disease - Arteriosclerotic type 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 8 days 5 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 24, 1961 to Feb. 2, 1961 , that (I) (we) last saw the deceased alive on Feb. 1, 1961 , and that death occurred on Feb. 2, 1961 at 1:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE James K. Gray		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) James K. Gray		22d. ADDRESS Thurmont, MD	
23a. BURIAL CREMATON, REMOVAL (Specify) Burial Feb. 5, 1961		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Utica Cem.		23d. LOCATION (City, town, or county) (State) Utica, Fredk. Co. MD	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		25a. REC'D BY REGISTRAR DATE FEB 7 '61	
25b. REGISTRAR'S SIGNATURE Robert L. Kraus			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1912

01888

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Creagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rocky Ridge RFD (Creagerstown)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Wesley Last Rensburg		4. DATE OF DEATH Month Feb. Day 3 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1880
9. AGE (In years last birthday) yrs. 80		10. UNDER 1 YEAR Months 8 Days 15 Hours 15 Min.	11. UNDER 24 HRS Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Rubber factory	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Emanuel Rensburg		14. MOTHER'S MAIDEN NAME Louisa Green	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-24-9900	
17. INFORMANT Mrs. Edna W. Rensburg		Address Rocky Ridge, Md	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 332X cerebral thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cerebral arteriosclerosis (c) 2 yrs.		INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 28, 1961 to Feb. 3, 1961 , that (I) (we) last saw the deceased alive on Feb. 1, 1961 , and that death occurred at 6 A.M. from the causes and on the date stated above.			
22a. SIGNATURE James K. Gray		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) James K. Gray		22d. ADDRESS Thurmont, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-5-61	
23c. NAME OF CEMETERY OR CREMATORY Creagerstown Cemetery		23d. LOCATION (City, town, or county) (State) Creagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond C. Creager		25a. REGISTERED BY REGISTRAR Feb 7 1961	
ADDRESS Thurmont, Md.		25b. REGISTRAR'S SIGNATURE Arthur E. Kious	

Page 4

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the attending physician and completely filled in by the funeral director, may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1913

CERTIFICATE OF DEATH

01889

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown			c. LENGTH OF STAY IN lb life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS East Main Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Walter Middle L. Last Remsberg				4. DATE OF DEATH Month 2 Day 22 Year 19 61			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/9/1879		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) insurance agent		10b. KIND OF BUSINESS OR INDUSTRY insurance		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George I. Remsberg				14. MOTHER'S MAIDEN NAME Susan Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-32-5002		17. INFORMANT Address Mrs. Naomi Reusberg, Middletown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis, Profusely Cerebral DUE TO (c) Dilated Myocardium							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from June 1957 to Feb 22, 1961 , that (I) (we) last saw the deceased alive on Feb 21, 1961 , and that death occurred at 11:55 AM , from the causes and on the date stated above							
22a. SIGNATURE Dr. J. Elmer Harp		22b. DATE SIGNED 2-23-61		22c. PHYSICIAN'S NAME (Type) Dr. J. Elmer Harp		22d. ADDRESS Middletown, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) burial		23b. DATE THEREOF 2/25/1961		23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		23d. LOCATION (City, town, or county) (State) Middletown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company,				ADDRESS Middletown, Md.		25a. REC'D BY REGISTRAR FEB 27 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



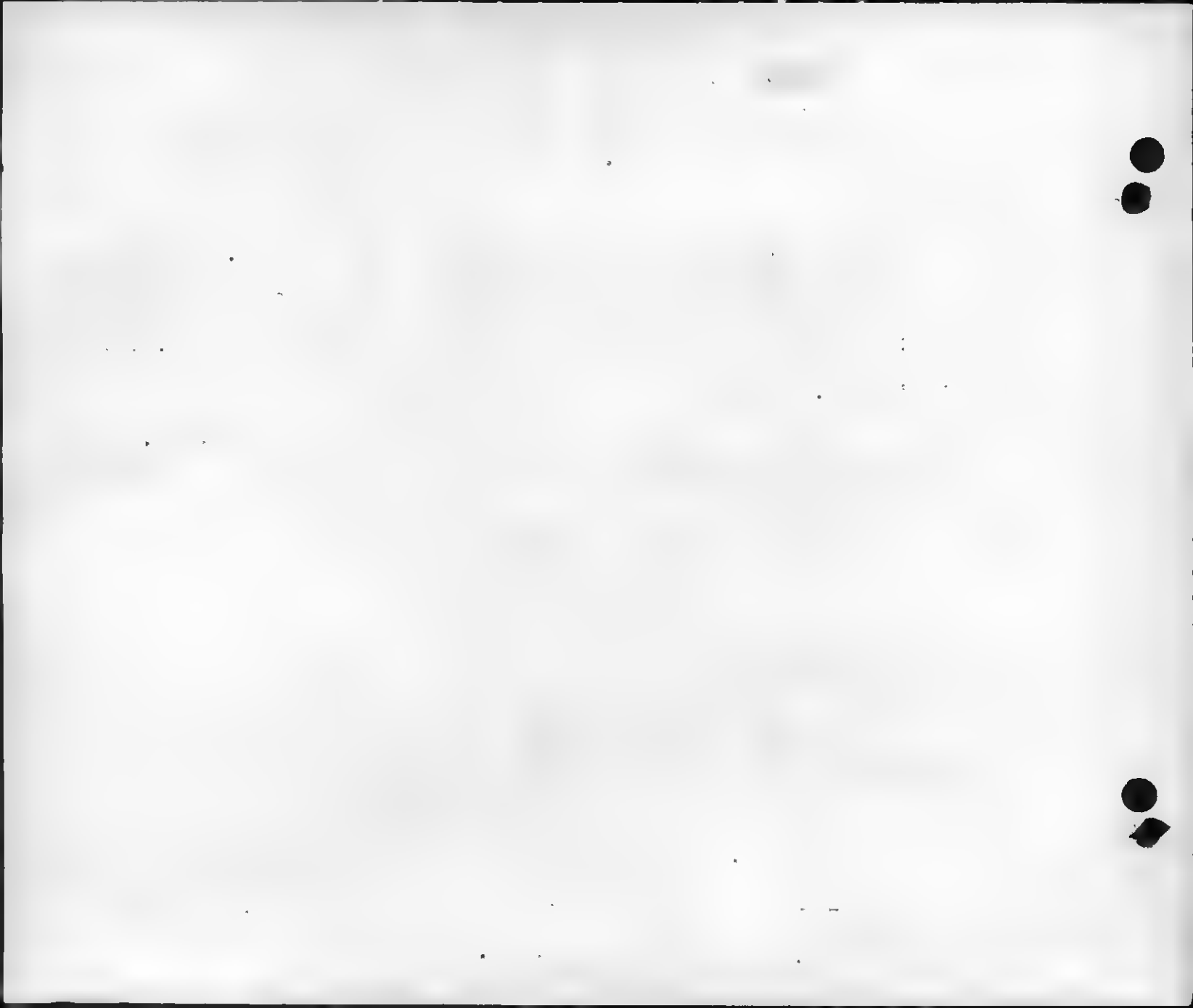
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01890

1914

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont		c. LENGTH OF STAY IN 1b 5 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Own Home		e. STREET ADDRESS Water Street	
3. NAME OF DECEASED (Type or print) First Mary Middle Jane Last Riffle		4. DATE OF DEATH Month Feb. Day 1 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 24, 1877
9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William T. Eyler		14. MOTHER'S MAIDEN NAME Margaret Eyler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT George Riffle Address Thurmont, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Uremic Toxemia 3924 DUE TO (b) Chronic interstitial nephritis Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH 3 days 5 years
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 20, 1961 to Feb 1, 1961 that (I) (we) last saw the deceased alive on Feb 1, 1961 and that death occurred on Feb 1, 1961 at 5 p.m. from the causes and on the date stated above			
22a. SIGNATURE James K. Gray		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) James K. Gray		22d. ADDRESS Thurmont, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-4-61	23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery	23d. LOCATION (City, town, or county) (State) Thurmont, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Raymond C. Crayon		25a. REC'D BY REGISTRAR DATE FEB 7 '61	
ADDRESS Thurmont, Md.		25b. REGISTRAR'S SIGNATURE Charles S. Evans	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and immediately filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

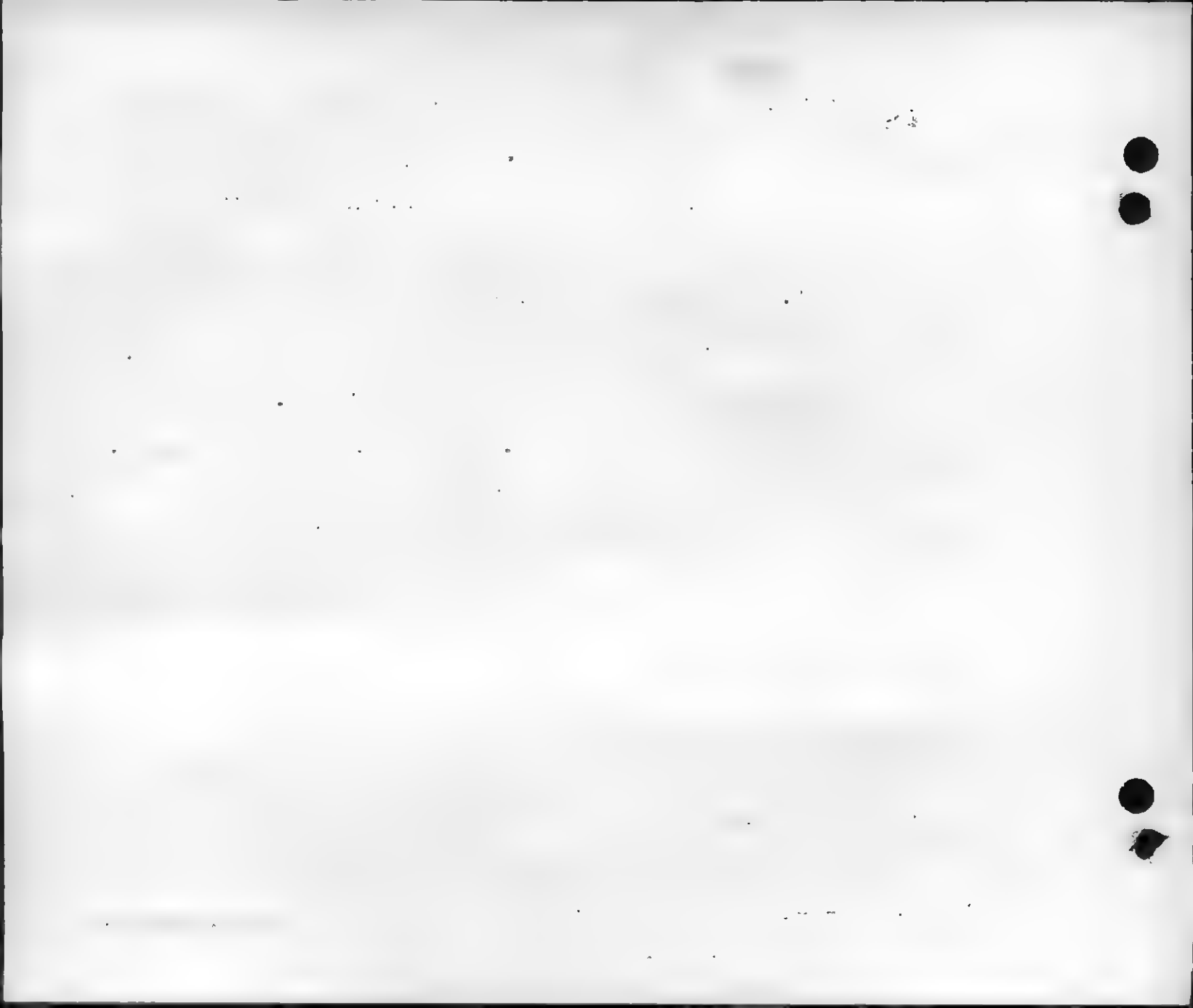


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

Page 4

VR AIS (4)
15M 9/59

<div> <div>1</div> <div>CHANNIE ROSE</div> <div>1915</div> <div>01891</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div>											
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Frederick							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN TB Life				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital				d. STREET ADDRESS 28 Lincoln Apartments				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Carrie Middle Emma Last Rose				4. DATE OF DEATH Month 2 Day 28 Year 1961							
5. SEX Female		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-19-1902		9. AGE (In years last birthday) 50 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Will Woodard				14. MOTHER'S MAIDEN NAME Mary Hill							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Evelyn Burnett, Frederick, Md.				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 451X Thrombosis of Aorta Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Aneurysm of Aorta (c) Meseurine Thrombosis										INTERVAL BETWEEN ONSET AND DEATH Days Yes	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1954 to 2-25-1961, that (I) (we) last saw the deceased alive on 2-27-1961, and that death occurred at 9:50 PM, from the causes and on the date stated above.											
22a. SIGNATURE Rox R. Hinton				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Rox R. Hinton				22d. ADDRESS 2200 Wakefield Rd. N.E. Wash D.C.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1-4-1961		23c. NAME OF CEMETERY OR CREMATORY Fairview		23d. LOCATION (City, town, or county) (State) Frederick Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE B. H. Felt				ADDRESS Brunswick, Maryland		25a. REC'D BY REGISTRAR DATE MAR 2 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



Page 4
TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned to the hospital or attending physician by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

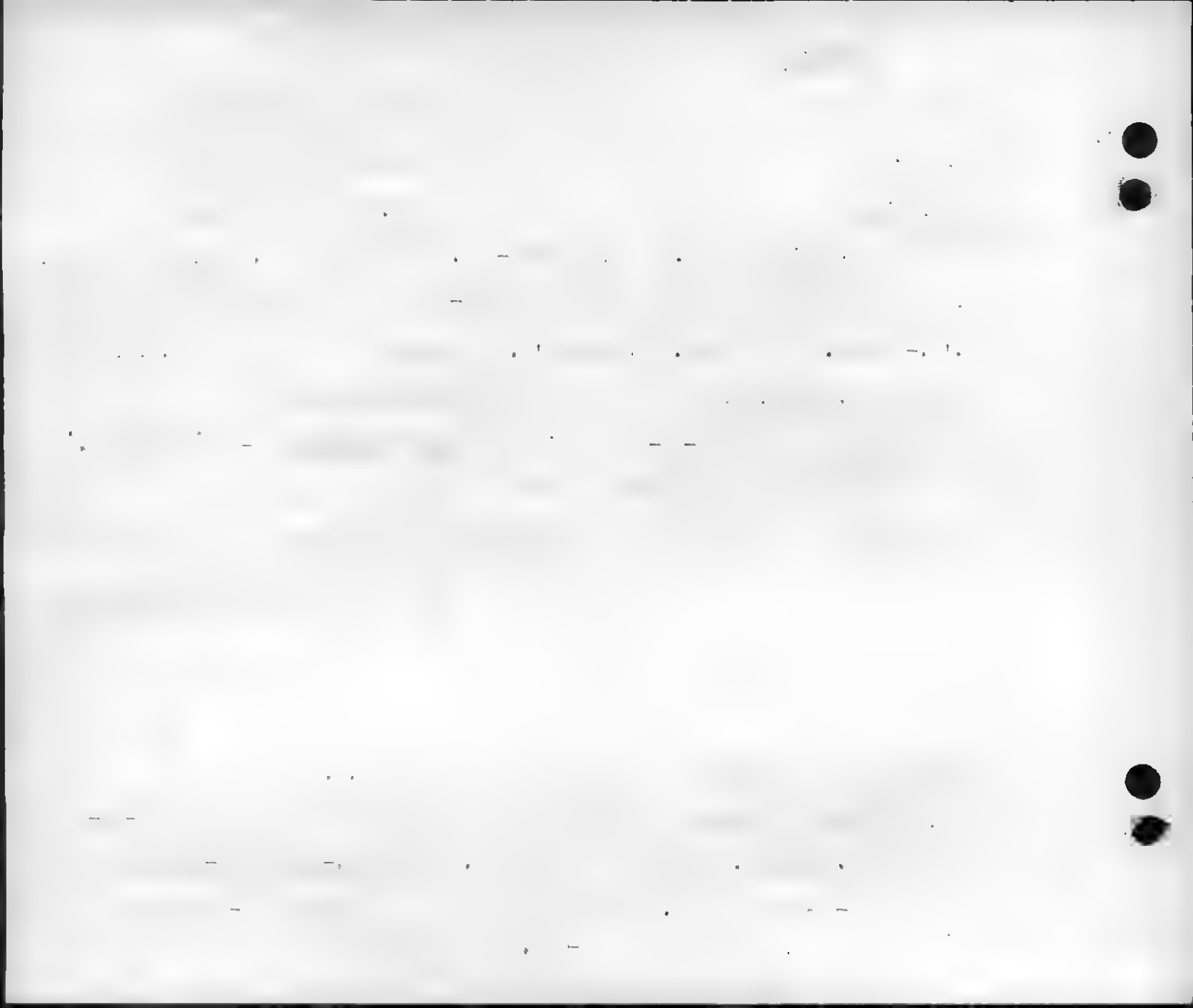
VR AIS (4)
15M 9/59

1916

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01892

1 PLACE OF DEATH a. COUNTY Frederick		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
		d. STREET ADDRESS 322 W. College Terrace	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Francis B. Sappington- Jr.		4. DATE OF DEATH Month Feb. Day 10 Year 19 61	
5. SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8-1887
9. AGE (In years lost birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sec'y.- Treas.		10b. KIND OF BUSINESS OR INDUSTRY Bldg. & Loan Ass'n.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis B. Sappington		14. MOTHER'S MAIDEN NAME Mary Rebecca Angell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWar 1		16. SOCIAL SECURITY NO. 218-03-5433	
17. INFORMANT Miss Mary Angell Sappington- Frederick-Md.		Address 127 W. Church St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Congestive Heart failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 10 yrs + Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 24 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c): 1) Diabetes mellitus 2) Hypoproteinemia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 10/24 19 60 to 2/10 19 61 , that (I) (we) last saw the deceased alive on 2/10 19 61 , and that death occurred at 4:50 A.M. the causes and on the date stated above.			
22a. SIGNATURE Henry V. Chase		22b. DATE SIGNED 2-10-1961	
22c. PHYSICIAN'S NAME (Type) Dr. Henry V. Chase		22d. ADDRESS 4 E. Church St.-Frederick- Maryland	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-13-1961	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick- Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Dailey & Sons Funeral Home By E. J. Williams		25a. REC'D BY REGISTRAR DATE FEB 15 '61	
ADDRESS Frederick- Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1917

01893

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 37 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS 272 West Fifth Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HARRISON Last SHANKIE				4. DATE OF DEATH Month February Day 7 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 23, 1889		9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Grade School		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel O. Shankle				14. MOTHER'S MARRIED NAME Annett Staley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-18-7161		17. INFORMANT Mrs. Jessie L. Shankle-Same as Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with congestive failure 420.0 DUE TO (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 1 week							INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 1960 to 2-7-1961 , that (I) (we) last saw the deceased alive on 2-7-1961 , and that death occurred at 9:30 PM from the causes and on the date stated above.							
22a. SIGNATURE Rex R. Martin				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 2/9/1961	
22c. PHYSICIAN'S NAME (Type) Rex R. Martin, M.D.				22d. ADDRESS 220 North Market Street, Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 11, 1961		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				25a. REC'D BY REGISTRAR DATE FEB 10 '61		25b. REGISTRAR'S SIGNATURE Arthur E. Hines	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1910

12 15 2 02 400

2 - 1 5
interior map

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1918

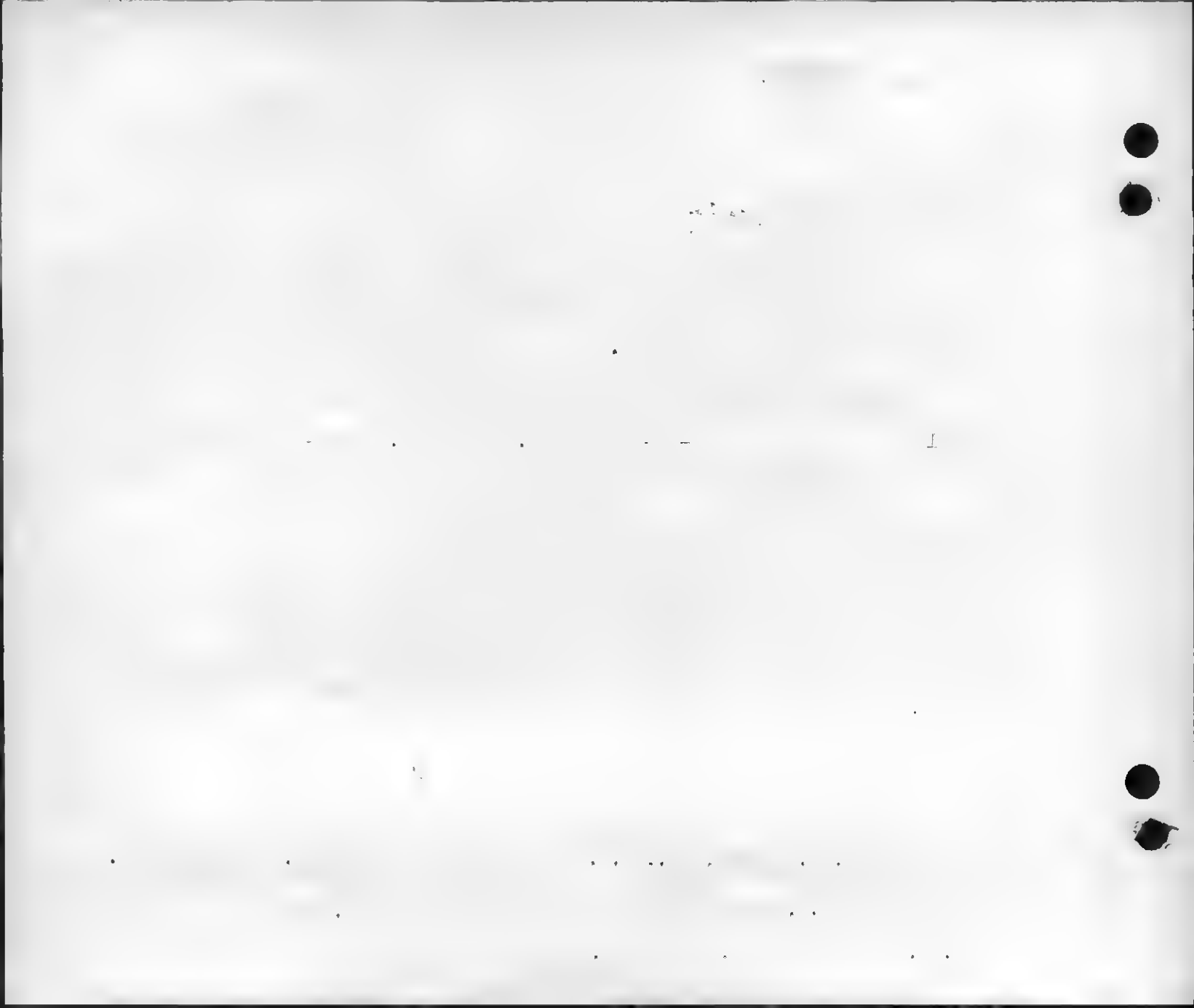
CERTIFICATE OF DEATH

01894

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8 Franklin Street		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 18 Franklin Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle ALBERT Last SHOWE		4. DATE OF DEATH Month February Day 4 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 22, 1895
9. AGE (In years last birthday) 65		10. IF UNDER 1 YEAR Months 6 Days 1 Hours 1 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Lime Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Franklin Showe		14. MOTHER'S MAIDEN NAME Mary Ellen Sumen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WWI		16. SOCIAL SECURITY NO 214-10-1666AB	
17. INFORMANT Address Mrs. Rosalie M. Showe—Same as Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 422X DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Sp. Cal. vessel rupture (c) Sp. Cal. vessel rupture PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2-6 1959 to 1-30 , 1961, that (I) (we) lost saw the deceased alive on 1-30 , 1961, and that death occurred at 8A M, from the causes and on the date stated above			INTERVAL BETWEEN ONSET AND DEATH 2 h. 25 min.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-6 , 1959, to 1-30 , 1961, that (I) (we) lost saw the deceased alive on 1-30 , 1961, and that death occurred at 8A M, from the causes and on the date stated above			
22a. SIGNATURE U. G. Bourne, Jr., M.D.		22b. DATE SIGNED 2/6/1961	
22c. PHYSICIAN'S NAME (Type) U. G. Bourne, Jr., M.D.		22d. ADDRESS West All Saints St., Frederick, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 6, 1961	
23c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery		23d. LOCATION (City, town, or county) (State) Mt. Airy, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR DATE FEB 7 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas		25c. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01895

1919

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b 3 Years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 12 John Hanson Apt. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last Lemard Edward Sier				4. DATE OF DEATH Month Day Year Feb. 23 1961									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 14, 1915							
9. AGE (in years last birthday) 45 yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) Ijamsville, Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY									
13. FATHER'S NAME Claude Sier				14. MOTHER'S MAIDEN NAME Nettie Perkins									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 215 14 2038		17. INFORMANT Address Mrs. Mabel Sier, 12 John Hanson Apt. Frederick, Md.									
MEDICAL CERTIFICATION						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Constrictive Heart Failure DUE TO (c) Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH 10 years 1 year 5 days					
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
						20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
						20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1 , 19 54 to Feb 23 , 19 61 , that I last saw the deceased alive on Feb 23 , 19 61 , and that death occurred at 11:54 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4613 3rd St Frederick DATE SIGNED 2-23 ACTUAL SIGNATURE Thomas E. Stone M.D. PHYSICIAN'S NAME (Type) Thomas E. Stone													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/25/61		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet		22d. LOCATION (City, town, or county) (State) Frederick Maryland.							
23. FUNERAL DIRECTOR'S SIGNATURE M.R. Fitchison & Son, 106 E. Church St. Frederick, Md.				24a. REC'D BY REGISTRAR DATE FEB 27 '61		24b. REGISTRAR'S SIGNATURE Clara S. Kraus							

TO HOSPITAL, ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 01896

1920

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ROUTE 2</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES HAMMOND SMITH</u>				4. DATE OF DEATH Month Day Year <u>FEB 2 1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR-22-1888</u>		9. AGE (In years last birthday) <u>72</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES J SMITH</u>				14. MOTHER'S MAIDEN NAME <u>IDA HAMMOND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>1 WWI</u>				16. SOCIAL SECURITY NO. <u>215-208221</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Dilatation</u> <u>422-2</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 4 1960</u> to <u>Feb 3 1961</u> , that I last saw the deceased alive on <u>1-25-1961</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. N. Legg</u> M.D.				ADDRESS (Street, city or town, state) <u>Union Bridge, Md 2-3-61</u>			
PHYSICIAN'S NAME (Type) <u>Dr. T. H. Legg</u>				DATE SIGNED <u>UNION BRIDGE MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/6/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FAIRMOUNT</u>		22d. LOCATION (City, town, or county) (State) <u>LIBERTY TOWN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DD HARTZLER & SONS</u> ADDRESS <u>Union Bridge, Md</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 7 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1922 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **01898**

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 11 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A.—Frederick Memorial Hospital		e. STREET ADDRESS 128 South Market Street	
3. NAME OF DECEASED (Type or print) First ADA JANE Middle ELIZABETH Last STINE		4. DATE OF DEATH Month February Day 24 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1883
9. AGE (In years birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Young		14. MOTHER'S MAIDEN NAME Abbie Bussard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mr. Preston V. Stine, Frederick, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY THROMBOSIS		INTERVAL BETWEEN ONSET AND DEATH Minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) DUE TO (c) DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. O. Thomas M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. Thomas, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/1961	
22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Middletown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR FEB 28 '61	
		24b. REGISTRAR'S SIGNATURE Carlton S. Howard	



1923

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Page 4

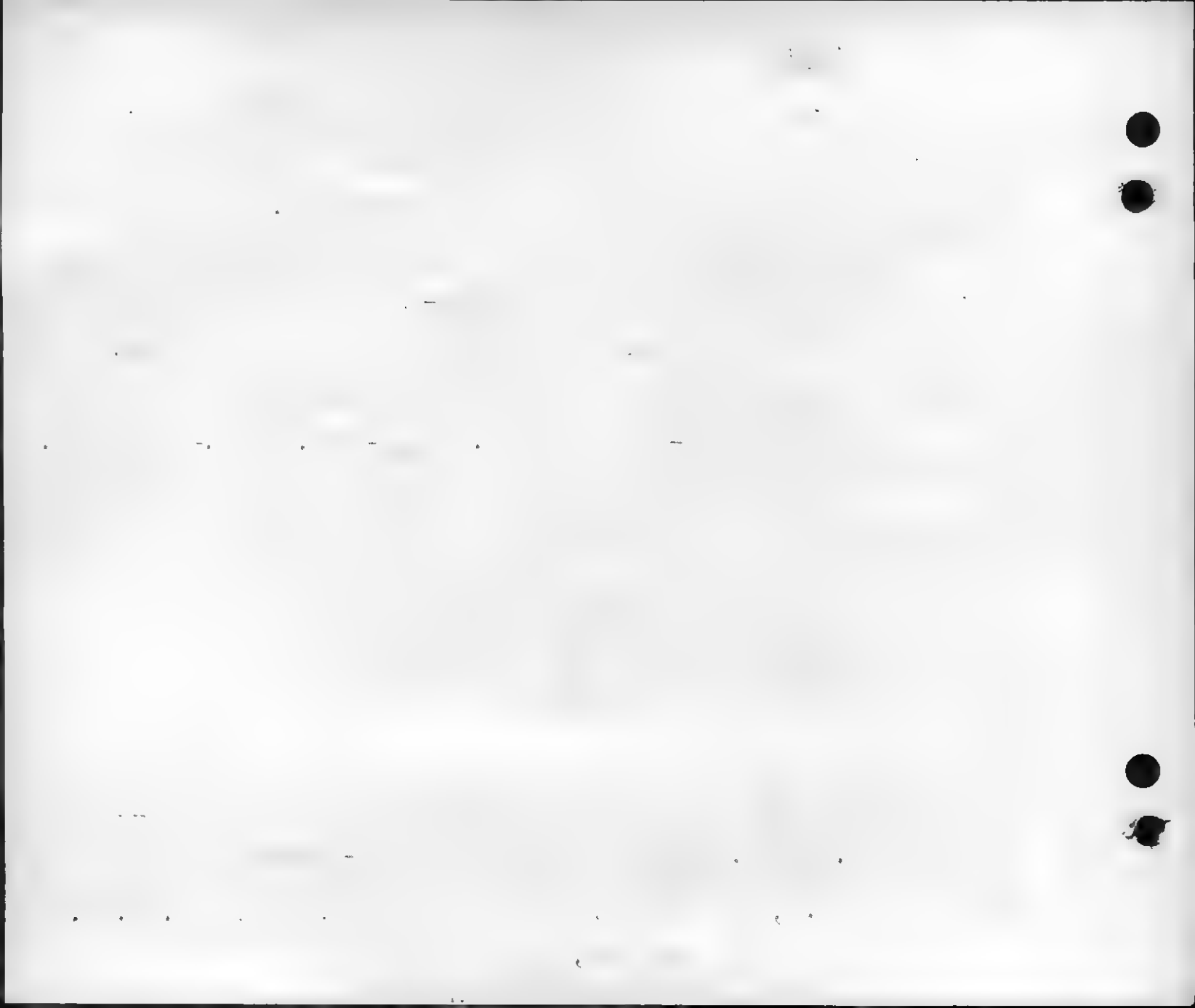
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01899

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Ladiesburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Carrie Middle May Last Stitely				4. DATE OF DEATH Month February Day 6 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 16-1915	
9. AGE (In years last birthday) 45 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles E. Bruchey				14. MOTHER'S MAIDEN NAME Carrie May McKinney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 220-01-1289		17. INFORMANT Grant L. Stitely-127 E. 6th St.-Frederick-Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 18c.7 IMMEDIATE CAUSE (a) Sarcomatous metastasis to brain DUE TO (b) to brain DUE TO (c) to brain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 1956 to Feb 7 1961 , that (I) (we) last saw the deceased alive on Feb 4 1961 , and that death occurred at 3:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE Dr. James E. Stoner				22b. ADDRESS Walkersville- Maryland		22c. PHYSICIAN'S NAME (Type) Dr. James E. Stoner	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Feb. 9, 1961		23c. NAME OF CEMETERY OR CREMATORY Fairmont Cemetery	
23d. LOCATION (City, town, or county) Libertytown, Fred. Co. Md.				23e. DATE FEB 9 '61		23f. REGISTRAR'S SIGNATURE Arthur L. Fries	
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dickey				24a. ADDRESS Frederick, Maryland		24b. REGISTRAR'S SIGNATURE Arthur L. Fries	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



Page 4
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1924

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

019110

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 50 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 250 Dill Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SARAH Middle AUGUSTA Last STOTELMYER				4. DATE OF DEATH Month February Day 8 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 10, 1870	
9. AGE (In years lost birthday) 90 yrs		10. IF UNDER 1 YEAR Months 90 Days 0 Hours 0 Min. 0		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work				10b. KIND OF BUSINESS OR INDUSTRY At Home			
13. FATHER'S NAME Andrew Miller				14. MOTHER'S MAIDEN NAME Harriet C. Shuff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Beatrice V. Miller-Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senility DUE TO 174 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 174 X DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 year			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Frederick				20g. (County) Frederick		20h. (State) Maryland	
21. I certify that (I) (this hospital) attended the deceased from 2-1-1960 to 2-8-1961 , that (I) (we) last saw the deceased alive on 2-1-1961 , and that death occurred at 12:30 P.M. on the causes and on the date stated above							
22a. SIGNATURE Rex R. Martin				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/9/1961	
22c. PHYSICIAN'S NAME (Type) Rex R. Martin, M.D.				22d. ADDRESS 220 North Market Street, Frederick, Md.			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 11, 1961		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				25a. REC'D BY REGISTRAR FEB 10 '61		25b. REGISTRAR'S SIGNATURE Charles L. Hume	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1925

01901

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 yr. 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Three Pines Nursing Home		d. STREET ADDRESS 1 East Street	
3. NAME OF DECEASED (Type or print) First Emma Middle Last Stowe		4. DATE OF DEATH Month February Day 4 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1867
9. AGE (In years (month birthday) yrs) 93		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Conrad Margardt		14. MOTHER'S MAIDEN NAME Sophia Rosine Roelky	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Three Pines Conv. Home records Fred. Md
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senility 794x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 5-10 YEARS
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-1-1955 to 2-4-1961 , that (I) (we) last saw the deceased alive on 1-17-1961 , and that death occurred at 4:30 PM , from the causes and on the date stated above			
22a. SIGNATURE Rex R Martin		22b. DATE SIGNED 2-5-61	
22c. PHYSICIAN'S NAME (Type) Rex R Martin		22d. ADDRESS 220 N. MARKET Frederick Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-7-61	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town, or county) (State) Frederick, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		25a. REC'D BY REGISTRAR DATE FEB 8 '61	
ADDRESS Thurmont, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

Y. T. 1. 4. 2

2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

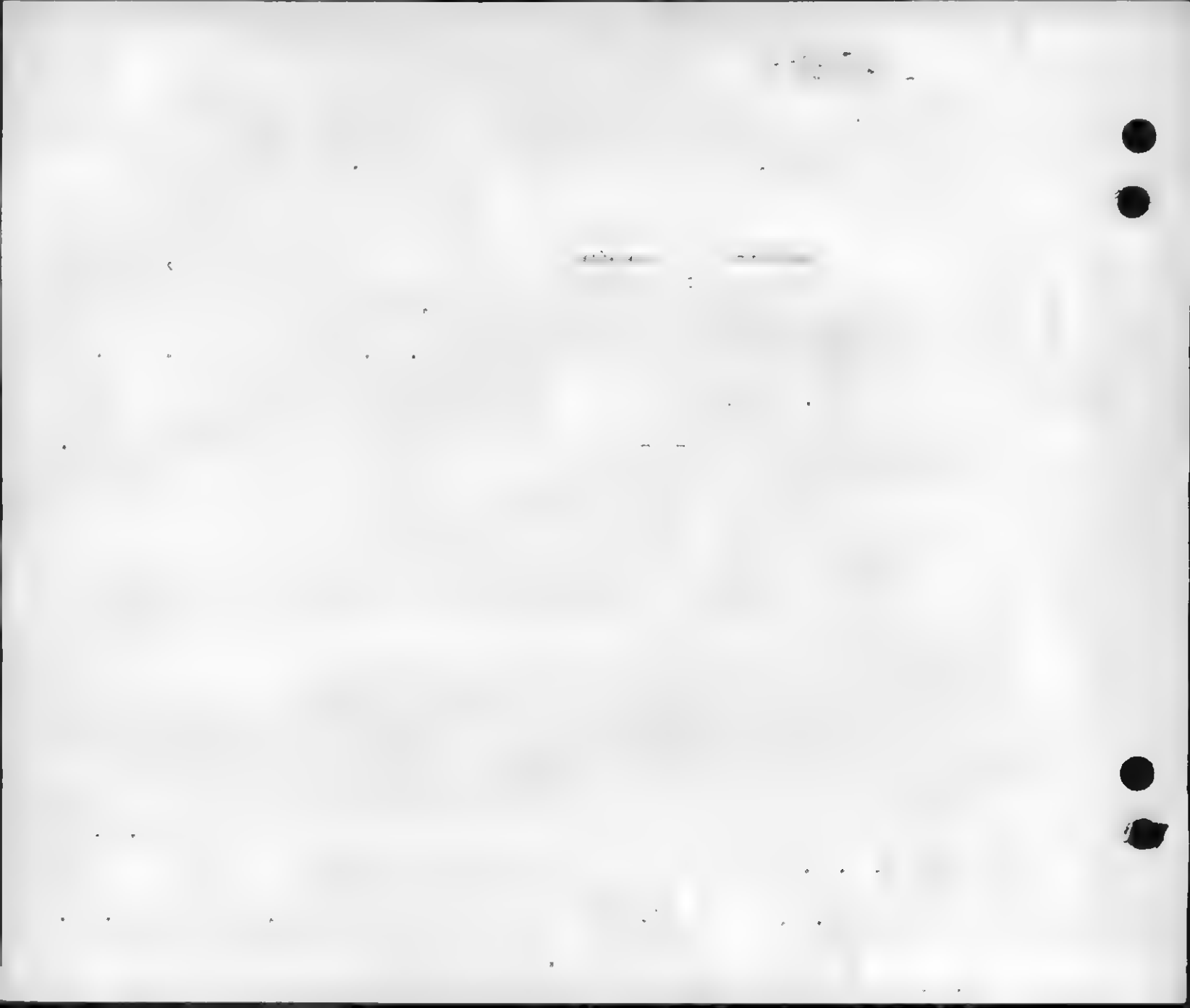
1926 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01912

FOR STATE
HEALTH DEPT.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Emmitsburg, | c. LENGTH OF STAY IN 1b
16 years | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Emmitsburg, | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
400 West Main Street | | d. STREET ADDRESS
400 West Main Street | |
| 3. NAME OF DECEASED (Type or print)
First Theodore Middle Franklin Last Summers | | 4. DATE OF DEATH
Month February Day 20 Year 19 61 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
February 5, 1902 |
| 9. AGE (In years, last birthday)
59 yrs. | | IF UNDER 1 YEAR
Months 59 Days 59 | IF UNDER 24 HRS.
Hours 59 Min. 59 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machine operator | | 10b. KIND OF BUSINESS OR INDUSTRY
Pipe & Nipple | |
| 11. BIRTHPLACE (State or foreign country)
Adams Co. Pa. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Charles D. Summers | | 14. MOTHER'S MAIDEN NAME
Alverta Loy | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
188-16-7229 | |
| 17. INFORMANT
Mrs. Pauline Summers | | Address 400 West Main Emmitsburg, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction
42 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 42 DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH
24 hours |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 19 p. m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE B. O. Thomas | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Dr. B. O. Thomas | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED
Feb. 20, 1961 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
Feb. 23, 1961 | 22c. NAME OF CEMETERY OR CREMATORY
Mt. View | 22d. LOCATION (City, town, or county) (State)
Emmitsburg, Frederick Co. Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
C. E. Wilson | | 24a. REC'D BY REGISTRAR
Feb 24 '61 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01913

1927

| | | | |
|---|---|---|---|
| 1 PLACE OF DEATH
a. COUNTY Frederick MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frederick | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frederick | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Frederick Memorial Hospital | | d. STREET ADDRESS
122 Pine Avenue | |
| 3. NAME OF DECEASED (Type or print)
First HOWARD Middle GREENWOOD Last TAYLOR, SR. | | 4. DATE OF DEATH
Month February Day 7 Year 19 61 | |
| 5 SEX
Male | 6 COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5 July 1875 |
| 9. AGE (In years last birthday)
85 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Owner Memorial Monument Dealer | | 10b. KIND OF BUSINESS OR INDUSTRY
Maryland | |
| 11 BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Thomas Taylor | | 14. MOTHER'S MAIDEN NAME
Agnes J. Lovell | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Mrs. Erma R. Taylor (Same as item #2) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intestinal Hemorrhage
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Eroded Duodenal Ulcer ?
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH
24 Hours |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Feb 6 , 19 61 , to Feb 7 , 19 61 , that (I) (we) last saw the deceased alive on Feb 7 , 19 61 , and that death occurred at 8:10 AM , from the causes and on the date stated above | | | |
| 22a. SIGNATURE
B. O. Thomas | | 22b. DATE SIGNED
8 Feb 61 | |
| 22c. PHYSICIAN'S NAME (Type)
B. O. Thomas, M. D. | | 22d. ADDRESS
228 N. Market St., Frederick, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
2-10-61 | 23c. NAME OF CEMETERY OR CREMATORY
Mount Olivet Cemetery | 23d. LOCATION (City, town, or county) (State)
Frederick, Maryland |
| 24. FUNERAL DIRECTOR'S SIGNATURE
M. R. Etchison & Son, Frederick, Maryland | | 25a. REC'D BY REGISTRAR
DATE FEB 10 '61 | |
| | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Kraus | |

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01914

1928

CERTIFICATE OF DEATH

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>FREDERICK</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Union Bridge</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Union Bridge</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Bridge</u> | | d. STREET ADDRESS <u>6x2</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>P</u> Middle <u>R</u> Last <u>Testerman</u> | | 4. DATE OF DEATH
Month <u>Feb</u> Day <u>27</u> Year <u>1961</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1.6.23.1961</u> |
| 9. AGE (In years last birthday) <u>38</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>15</u> Hours <u>15</u> Min <u>5</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>United States</u> | |
| 13. FATHER'S NAME <u>John P. Testerman</u> | | 14. MOTHER'S MAIDEN NAME <u>Esther A. Testerman</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>NOBLE TESTERMAN</u> | | Address <u>Union Bridge Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Military attack</u>
<u>762.5</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PREMATURITY</u>
(c) <u>PREMATURITY</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
<u>19</u> | 20d. INJURY OCCURRED
Where of work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>24 Feb</u> 19 <u>61</u> to <u>27 Feb</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>27 Feb</u> 19 <u>61</u> , and that death occurred at <u>10</u> M, from the causes and on the date stated above | | | |
| 22a. SIGNATURE <u>F. J. Heldrich Jr</u> | | 22b. DATE SIGNED <u>24 Feb 61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>F. J. HELDRICH JR</u> | | 22d. ADDRESS <u>FREDERICK, Maryland</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>2/25/61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEM</u> | 23d. LOCATION (City, town, or county) (State) <u>CARROLL COUNTY MD</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Hartz</u> | | 25a. REC'D BY REGISTRAR <u>27 Feb 61</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>W. H. Hartz</u> | | 25c. REGISTRAR'S SIGNATURE <u>W. H. Hartz</u> | |



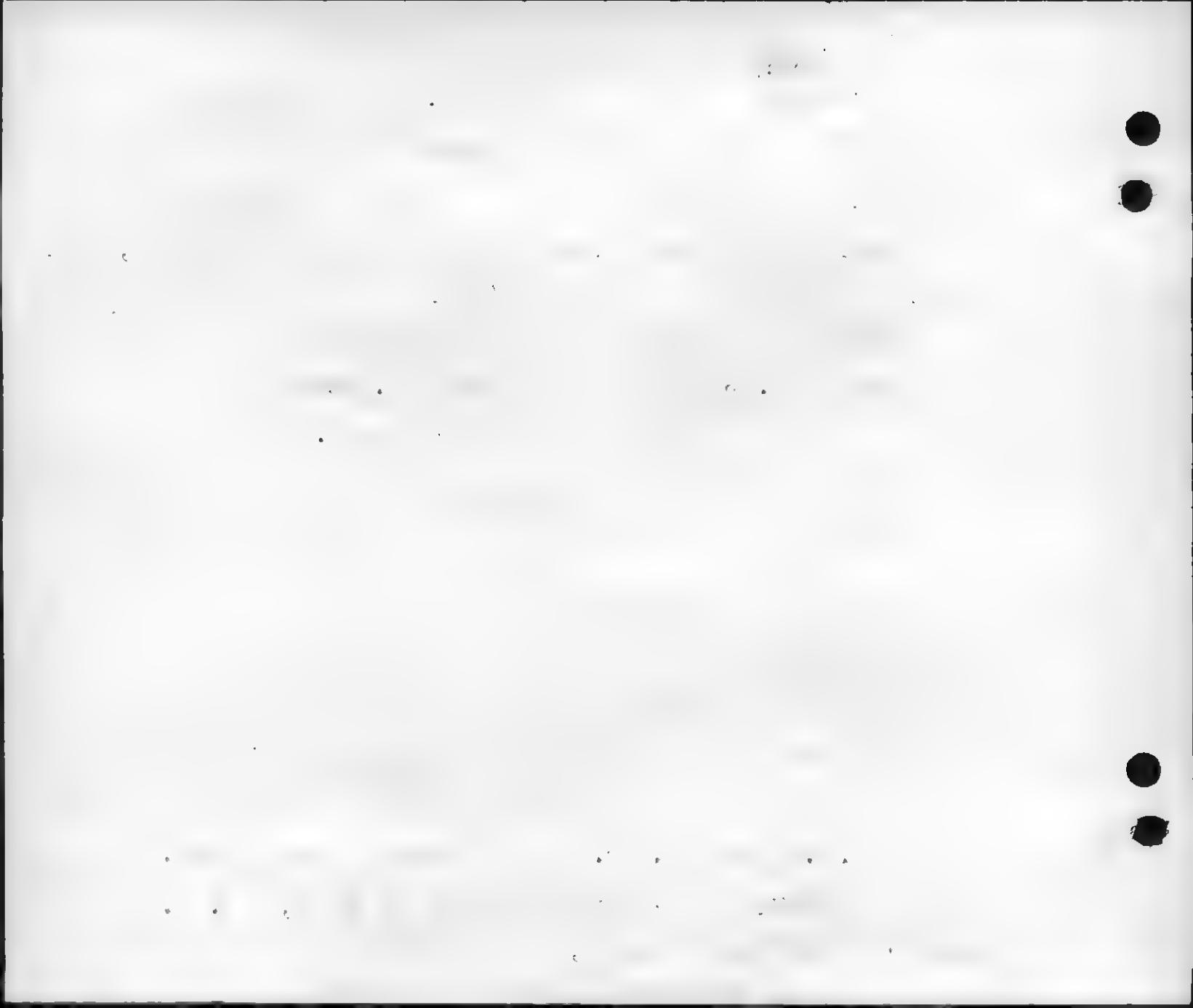
Page 4
 TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/59

1 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND 1929 CERTIFICATE OF DEATH

01975

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Frederick
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission)
o. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FREDERICK | | c. LENGTH OF STAY IN 1b
Lifetime | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
FREDERICK MEMORIAL HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Infant Terry Frances Tolbard Tolbard | | 4. DATE OF DEATH
Month February Day 25 , Year 1961 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/25/61 |
| 9. AGE (In years last birthday) yrs | | 10. IF UNDER 1 YEAR
Months 6 Days 30 | 11. IF UNDER 24 HRS
Hours 6 Min 30 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Infant | | 10b. KIND OF BUSINESS OR INDUSTRY
Infant | |
| 11. BIRTHPLACE (State or foreign country)
Frederick Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA. | |
| 13. FATHER'S NAME
William A. Tolbard | | 14. MOTHER'S MAIDEN NAME
Eleanor F. Calain | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
NO | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Hospital Records. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Immaturity
776X DUE TO (b)
Conditions, if only, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
6 Years | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 25 Feb 19 61 , to 2-27 Feb 19 61 , that (I) (we) last saw the deceased alive on 25 Feb 19 61 , and that death occurred at 6:15 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
A. M. Powell Jr. MD. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
A. M. POWELL Jr. MD. | | 22d. ADDRESS
Frederick Medical Center. | |
| 23a. BURIAL CREMATION REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
2/27/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Odd Fellows Cemetery | | 23d. LOCATION (City, town, or county) (State)
Elkins, W. Va. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
DAILEY'S FUNERAL HOME | | 25a. REC'D BY REGISTRAR
DATE MAR 6 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1930

01966

| | | | | | | | |
|--|----------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Frederick MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frederick | | c. LENGTH OF STAY IN 1b
Life | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frederick | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Frederick Memorial Hospital | | | | d. STREET ADDRESS
256 South Carroll Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First MARY Middle MARION Last TRACEY | | | | 4. DATE OF DEATH
Month February Day 2 Year 1961 | | | |
| 5 SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
7 April 1890 | | 9 AGE (In years last birthday) yrs
70 | IF UNDER 1 YEAR
Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House-work | | 10b. KIND OF BUSINESS OR INDUSTRY
At Home | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Melvin A. Oden | | | | 14. MOTHER'S MAIDEN NAME
Mary Kanode | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT Address
Miss Irene D. Tracey (Same as item #2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute bronchitis, pulmonary emphysema
3rd DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease | | | | | | INTERVAL BETWEEN ONSET AND DEATH
10 days - 10 years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 8/24 1959 to 2/2 1961 , that (I) (we) last saw the deceased alive on 2/2 1961 , and that death occurred at 7:45 P M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Richard C. Reynolds, M.D. | | | | 22b. DATE SIGNED
3 Feb 1961 | | 22c. PHYSICIAN'S NAME (Type)
Richard C. Reynolds, M. D. | |
| 22d. ADDRESS
9 E. Church St., Frederick, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2-6-61 | | 23c. NAME OF CEMETERY OR CREMATORY
Mount Olivet Cemetery | | 23d. LOCATION (City, town, or county) (State)
Frederick, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
M. R. Etchison & Son, Frederick, Maryland | | | | 25a. REC'D BY REGISTRAR
DATE FEB 7 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Harris | |

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your file.

VS AISM
5M 2/57

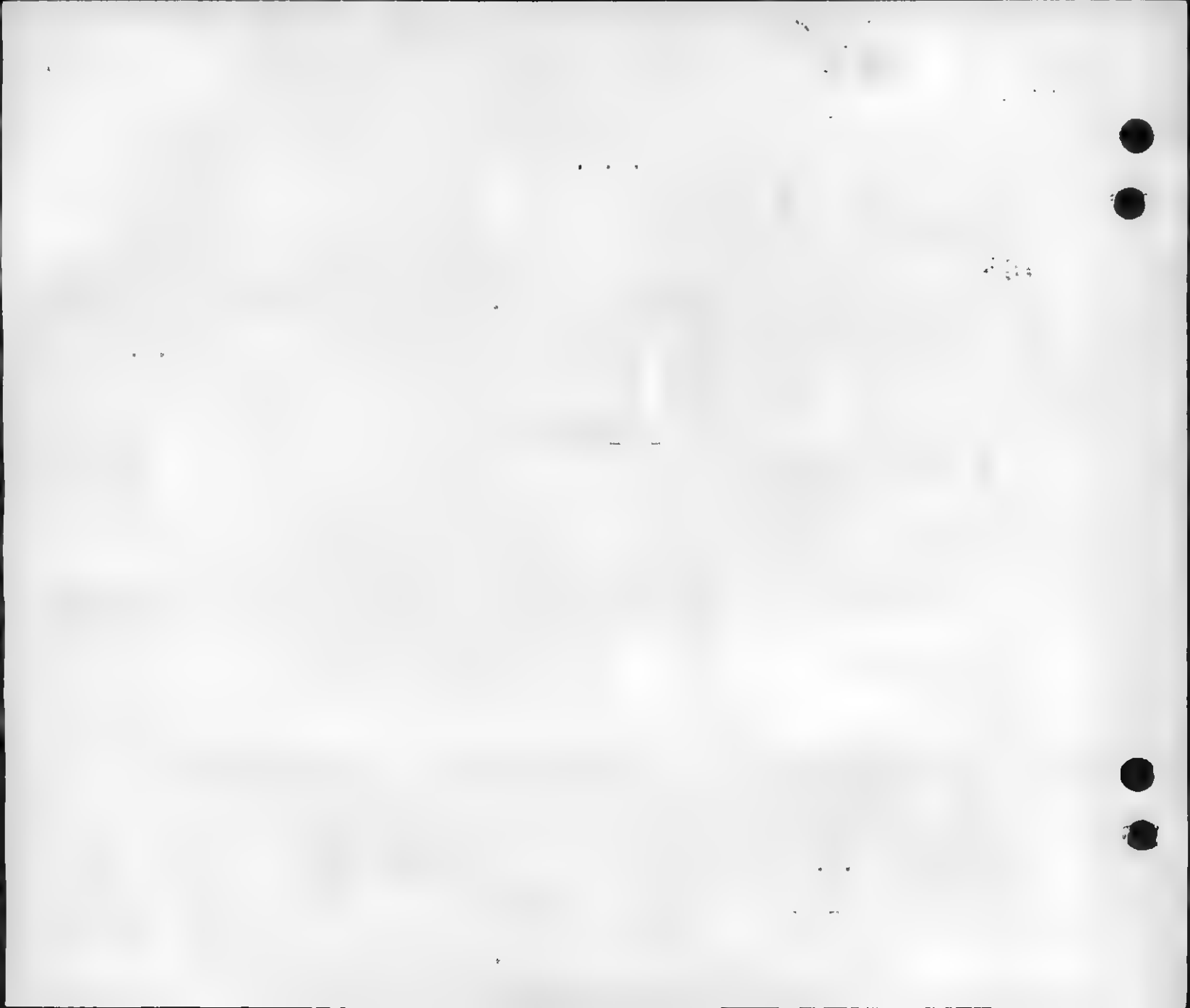
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1932 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01908

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Frederick MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Frederick | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest one) Frederick | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewistown | |
| c. LENGTH OF STAY IN ID D.O.A. | | d. STREET ADDRESS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Henry Ernest Warner | | 4. DATE OF DEATH February 16 19 61 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 16, 1879 |
| 9. AGE (In years last birthday) 81 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | 11. BIRTHPLACE (State or foreign country) Pennsylvania |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME William Warner | |
| 14. MOTHER'S MAIDEN NAME Martha Keiholtz | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. 217-28-5999 | | 17. INFORMANT Clarence Warner Address Lewistown Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion | | | |
| 420.1 DUE TO | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO | | | |
| (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE B.O. Thomas | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) B.O. Thomas | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2-19-61 | |
| 22c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery | | 22d. LOCATION (City, town, or county) (State) Thurmont, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Crager | | ADDRESS Thurmont, Md. | |
| 24a. REC'D BY REGISTRAR DATE FEB 20 '61 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

DATE SIGNED Feb. 17-1961



1933

CERTIFICATE OF DEATH

Reg. Dist. No.

01909

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY FREDERICK MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY FREDERICK ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FREDERICK | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
UNION BRIDGE | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
FREDERICK MEMORIAL HOSPITAL | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
MAURICE THOMAS WARNER | | | | 4. DATE OF DEATH Month Day Year
FEB 16 1961 | | | |
| 5. SEX
M | | 6. COLOR OR RACE
W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
AUG 30-1874 | |
| 9. AGE (In years last birthday)
86 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | | 11. IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CARPENTER | | | | 10b. KIND OF BUSINESS OR INDUSTRY
CARPENTER | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | |
| 13. FATHER'S NAME
JOHN THOMAS WARNER | | | | 14. MOTHER'S MAIDEN NAME
LYDIA ETZLER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
NO | | | | 16. SOCIAL SECURITY NO.
220-18-1897 | | | |
| 17. INFORMANT
REESE WARNER | | | | Address
RURAL MD UNION BRIDGE | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
904.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Compound Fracture of head of femur DUE TO
(c) 2 days
INTERVAL BETWEEN ONSET AND DEATH 2 Wks | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Patient slipped & fell in home. Fracturing Hip. | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. Feb 2 1961 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | |
| 20f. (City or town) (County) (State)
Union Bridge MD | | | | | | | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on Feb 16 1961 , and that death occurred at 11:10 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
J. H. MESSLER | | | | ADDRESS (Street, city or town, state)
UNION BRIDGE MD | | | |
| PHYSICIAN'S NAME (Type)
J. H. MESSLER, M.D. | | | | DATE SIGNED
2/17/61 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
2/19/61 | | 22c. NAME OF CEMETERY OR CREMATORY
BEAVER DAM | | 22d. LOCATION (City, town, or county) (State)
FREDERICK CO MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
W. Hartzler & Sons | | | | ADDRESS
Union Bridge MD | | 24a. REC'D BY REGISTRAR
DATE FEB 20 '61 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kline | | | |

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEEL

Page 4
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | |
|---|------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY FREDERICK
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D. C.
c. LENGTH OF STAY IN 1b 7 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Walter Reed General Hospital, Ft Detrick 5702 Colorado Ave. N.W. | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY WASHINGTON, D. C.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.
d. STREET ADDRESS 5702 Colorado Ave. N.W.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First JAMES Middle B. Last WARREN Jr. | | 4. DATE OF DEATH
Month Feb. Day 5 Year 19 61 | |
| 5. SEX MALE | 6. COLOR OR RACE Cau. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5 Dec. 1931 |
| 9. AGE (in years lost birthday) 29 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Military | | 10b. KIND OF BUSINESS OR INDUSTRY Air Force | |
| 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME JAMES B. WARREN Sr. | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 1952-1961 | |
| 17. INFORMANT Mrs. James B. Warren, Jr. (Wife) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia and hemorrhage
DUE TO 201X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hodgkins Disease
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 6 days
8 mos. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) Scheldon Kress attended the deceased from 30 Jan. 1961 to 5 Feb. 1961 , that (I) (X) last saw the deceased alive on 5 Feb. 1961 , and that death occurred at P. M. from the causes and on the date stated above. | | 22a. SIGNATURE Scheldon Kress M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22b. DATE SIGNED 5 Feb. 1961 | |
| 22c. PHYSICIAN'S NAME (Type) SCHELDON (NMI) KRESS, Capt, MC | | 22d. ADDRESS US Army Medical Unit, Ft. Detrick, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 2-9-61 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) AUGSBURG GERMANY | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Kissalli Funeral Home Inc ADDRESS 816 N.E. 1/4 St | | 25a. REC'D BY REGISTRAR FEB 14 '61 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Kress | | | |

